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Illinois Medical Journal

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY

Volume 152, Number 1 July 1977

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REPORT

X73-C461

FOR *Illinois Physicians*

State of Illinois Program Renewed With Blue Cross and Blue Shield

Illinois Blue Cross and Blue Shield will continue to administer the health care program of State of Illinois employees and their dependents for at least another year. The contract has been renewed for the fourth consecutive year, effective July 1, 1977 through June 30, 1978. There are no changes in the benefit structure of the program which provides coverage to over 130,000 employees.

Because of the large number of employees and dependents protected, the scope of benefits and filing procedures are summarized again as a service to physicians and their medical assistants:

PROGRAM SUMMARY

Payment of employee claims is based on Usual and Customary charges of physicians. The program incorporates coinsurance and deductible amounts at various levels. Options to cover dependents are provided at the same or reduced levels as employees and include the High Option Plan 11A; Low Option Plan 11B and 11C. Although the scope of benefit coverage is the same, payment levels are reduced, deductibles are increased and maximum payments lowered depending on the premium level of the plan selected by the employee.

Benefits of the High Option Plan 11 are as follows:

Physicians' Services

- In-hospital professional services, including surgery, surgical assistance, anesthesia, care of fractures and complete dislocations;
 - In-hospital medical care—365 days—including necessary consultations, intensive care, concurrent care, psychotherapy, inhalation therapy;
 - Maternity care and obstetrical services;
 - Home or office visits when related to an illness or injury that required hospitalization, up to a maximum of \$100 per person per contract year. Visits must be made within 90 days following hospital confinement.
- (The above services are payable at 80% Usual and Customary for expenses up to \$1,000; 90% U & C for the next \$2,000 of expenses; 100% U & C for expenses over \$3,000).
- Emergency medical and accident care if treated within 72 hours. Coverage is 100% Usual and Customary with no limitation.

- Diagnostic services are covered at 100% Usual and Customary up to a maximum of \$600 per year per person, excluding professional fees.

- Routine home or office visits not covered unless \$200 of such charges for an individual in a contract year has been reached. Coverage then at 50% Usual and Customary charges, not including routine lab and X-ray.

- Outpatient mental and nervous care covered at 50% Usual and Customary charges not to exceed payment of \$25 per day.

- Obstetrical: Single female employees covered as well as female dependents. Early OB and Terminal OB (coverage for delivery so long as conception occurred while female was covered under the program). Normal newborn care covered while hospitalized.

Medical Expense Benefits

Prescription Drugs—outside the hospital: A \$50 per person per contract year deductible applies and payment from \$50-\$1,000 per person, per year at 80%; \$1,000-\$3,000 at 90% and expenses over \$3,000 paid at 100% per person, per year.

There is a \$50 deductible for other medical expenses. The following coverages and coinsurance variables also apply:

- Rental or purchase of iron lung or other durable medical equipment; prosthetic appliances including leg braces; physical therapy rehabilitative services; renal dialysis; expenses above the outpatient diagnostic allowances.

- Coinsurance variables at 80% Usual and Customary for expenses up to \$5,000; 90% Usual and Customary for next \$5,000; and 100% Usual and Customary for expenses over \$10,000.

A special Medical Expense Benefit form must be used by state employees in filing their claims. Physicians enter the diagnosis, date of onset, first service, and sign the form.

Coordination of Benefits provisions apply throughout the entire program.

Coordination of Benefits with Medicare: Benefits will be paid up to the maximum prescribed for this program (or for whichever dependent option is selected), less those amounts paid by Medicare Parts A and B. (Blue Shield requires an Explanation of Medicare Benefits to pay its benefits).

(Continued on following page)

State of Illinois Employees Program

(Continued from preceding page)

Completing and Filing Claims

1) In completing the Blue Shield Physician's Service Report form for a State of Illinois employee or dependent, please use the Illinois Employees Group Insurance Program number 42500, and the employee's Social Security number. Do not use the patient's Social Security number unless the patient is the employee. To assure proper identification, ask the patient to present his Blue Shield State of Illinois Group Insurance Identification Card. The card will show the proper employee's Social Security number. If he does not have a card, please obtain this information before submitting the claim.

2) If you receive a State of Illinois Department inquiry form from Blue Shield with a Physician's Service Report attached, enter the Social Security number of the state employee on the inquiry form. Please do not use the physician's Social Security

number, nor the patient's (unless the patient is the employee). This will delay payment of the claim.

3) There are no special forms or service reports to submit. Please use the current Blue Shield Physician's Service Report form in submitting a claim.

Send Claims to Proper Claims Center

For convenience in filing State of Illinois employee claims and to speed payments, two special Claims Centers serve the program exclusively:

Claims from the northern portion of the state including Cook and the counties south to Hancock, McDonough, Fulton, Tazewell, McLean, Ford and Iroquois should be mailed to the Blue Shield Plan, 233 North Michigan Avenue, State of Illinois Department, 21st floor, Chicago, Illinois 60601.

Claims originating downstate in Adams, Schuyler, Mason, Logan, DeWitt, Champaign and Vermilion counties should be sent to the new Springfield office and Claim Center of the Blue Shield Plan, 200 Iles Park Place, Springfield, Illinois 62718.

ASK BLUE SHIELD . . . ABOUT MEDICARE

Coverage of Services and Supplies Furnished by Nonphysician Employees

Payment is made for services and supplies furnished "incident-to" a physician's professional service in the Medicare program, when such services and supplies are provided as part of the physician's professional service in the course of diagnosis or treatment of an injury or illness. Services and supplies should be of the kind commonly furnished in the doctor's office or clinic and are either provided without charge or are included in the physician's bills. In private practice the services are limited to those furnished under a doctor's direct supervision.

In a recent clarification of coverage guidelines, the Social Security Administration emphasized: (1) ancillary personnel rendering the "incident-to" services should be those employed by the doctor to perform such services and be under his direct personal supervision, and (2) that supplies furnished should represent a cost to the physician in his practice. Both should be billed to the Medicare carrier as physician charges for in-practice professional services. Reference to ancillary personnel was made for the services of nurses, nonphysician anesthetists, psychologists, technicians; also therapists, including physical therapists and speech therapists; as well as other such assistants and aides.

Although direct personal supervision does not require that the doctor *be present* when the service is performed, he is expected to be in his office or nearby and available for direction and assistance if necessary. It is also expected that he rendered the initial service to the patient and that subsequent service reflects his active participation in and management of the patient's course of treatment.

Where Laboratory Tests Are Performed Must Show On Claim Form Or Statement

The Bureau of Health Insurance, Social Security Administration, has again requested the cooperation of physicians to indicate the actual place laboratory services were performed, on either the 1490 Request for Medicare Payment form or the physician's billing statement.

If the tests were provided by an independent laboratory, the name of the laboratory must be shown on the claim. When tests were performed in the physician's office a statement should be made to that effect, such as "tests done in this office," or "own office" and indicated in Item 7B of the 1490 form or on the billing statement.

Claims for laboratory services that were formerly accepted without an indication of where they were performed will no longer be routinely processed by the Part B Medicare carrier.

SSA Change in Laboratory Certification

Notice was received from the Bureau of Health Insurance, Social Security Administration, of the closing of this laboratory, which participated in the Medicare program:

Roseland Clinical Laboratory
11418 South Michigan Avenue
Chicago, Illinois 60628
Provider Number: 14-8313
Effective Date: February 1, 1977

No payment can be made under the health insurance program for services rendered on or after February 1, 1977.



Illinois Medical Journal

JULY, 1977

Vol. 152, No. 1

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The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.



Abstracts of Board Actions

June 4-5, 1977

Chicago

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

Trustee Resignation, Appointment

The Board accepted "with regrets" the resignation of First District Trustee Dr. Joseph L. Bordenave, and appointed Dr. John J. Ring, Jr., Mundelein, to fill the trustee post until the 1978 annual meeting. Dr. Ring's appointment was based upon the recommendation of the Lake, McHenry and Kane County Medical Societies which comprise the First District.

Reschedule Interim House Session for Nov. 12-13

The 1977 Interim Session of the House of Delegates was rescheduled for Nov. 12-13, at the Sheraton St. Louis Hotel, St. Louis, with the Board scheduled to meet Friday, Nov. 11. The House of Delegates had requested that the originally-proposed Oct. 8-9 dates be changed due to a conflict with the annual meeting of the American Academy of Family Physicians.

Illinois Foundation for Medical Care

The Board of Trustees recommended that the ISMS Educational and Scientific Foundation provide an immediate loan of \$20,000 to IFMC and authorized the ISMS Executive Committee to loan additional funds—up to \$30,000—from the ISMS General Operating Fund upon presentation of justifiable reasons for so doing.

In a related action, the Board authorized payment of a \$19,736 outstanding bill from May and Speh for development of IFMC's physicians' billing system. Payment will be made from remaining funds in the negotiation assessment levied by the ISMS House of Delegates.

AMA Campaign Expenditures

In compliance with a House of Delegates directive, the Board reviewed the proposed budget for promotion of ISMS candidates for AMA offices and approved total expenditures of up to \$1,200 for the candidacies of: (1) Dr. David S. Fox for Council on Constitution & Bylaws; and (2) Dr. John J. Ring, Jr., for Council on Medical Service.

Travel Expenses

The Board approved a request by the Student Business Session and Resident Physician Section to appropriate \$3,600 from the special dollar assessment—established by the House of Delegates—to cover travel expenses for six representatives of those groups attending AMA's annual meeting in San Francisco.

Medicaid Problems

The Board approved revised drafts of the Physician-IDPA Agreement Form and Patient Consent Form (for release of medical records) developed by ISMS during negotiations with the Department.

(Continued on page 70)

OLBY PROCLAIMS WOMAN SUFFRAGE

gns Certificate of Ratification
at His Home Without
Women Witnesses.

LITANTS VEXED AT PRIVACY.

anted Movies of Ceremony,
But Both Factions Are

ASHINGTON, Aug. 26, 1920—
struggle for Woman



TRUMAN CLOSES ED NATIONS CONFERENCE TH PLEA TO TRANSLATE HARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great
Instrument of Peace,'
Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing
ation as Executive
ictures Peace Gain

Social Security Bill Is Signed; Gives Pensions to Aged, Jobless

Roosevelt Approves Message Intended to Benefit 30,000,000
Persons When States Adopt Cooperating Laws—He Calls
the Measure 'Cornerstone' of His Economic Program

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution
is Sent to House, Where
Passage is Expected

WASHINGTON, March 10,
1971—The Senate approved
today, 94 to 0, and sent to
the House for passage

WASHINGTON, Aug. 14,
The Social Security Bill, pro-
a broad program of unemplo-
insurance and old age pen-
and counted upon to benefit
20,000,000 persons, became law
day when it was signed by Pres-
dent Roosevelt in the presence of
those chiefly responsible for
working it through Congress.

Mr. Roosevelt called the measure
"the cornerstone in a structure
which is being built, but is
meant to complete the
structure."

SIGN THE DRAFT Ends Now

"If we fail to use it," he declared
to the solemn final meeting of the
delegates, "we shall betray all of
those who have died in order that
we might meet here in freedom and
safety to create it."

"If we seek to use it selfishly—for
the advantage of any one nation or
any small group of nations—we
shall be equally guilty of that be-
trayal."

Fervent Interpolation
The President, speaking in the
auditorium of the War Memorial
Opera House, built in memory of
sons of the Golden Gate city who
gave their lives in the first World
War, in which he himself served,
seemed to give unconscious expres-
sion to the solemn feeling of the
occasion when, at the outset of his
speech, he interpolated the words:
"half a hope, half a prayer:
"Oh, what a great day this can
be in history!"

Just before the plenary session

WASHINGTON, Jan. 27,
1973—"With the signing of
the peace agreement in
Paris today, and after re-
ceiving a report from the



Editorials



Notes on a Centennial Celebration

This month, the Illinois Department of Public Health celebrates the one hundredth anniversary of its founding. Their centennial of public service initiated with the dual goals of ensuring high quality medical care and a healthy environment. In 1977, IDPA culminates continued improvements and expansions with a range of services that cannot fail to reach every citizen in the state.

IDPH has grown from inceptive programs for public sanitation to sophisticated technological regulation of nuclear power plants. In those interim years of growth, the Department shouldered responsibility for community crises brought on by epidemics of cholera, smallpox, diphtheria, influenza, tuberculosis, and poliomyelitis. In the 19th century, IDPH conducted the first census in Illinois. Nutritional programs during the Depression, water and milk inspections during the great midwestern drought of the 1930's, and blood drives during World War II, were among the areas confronted—and resolved—by the burgeoning agency.

Through their educational, investigational and organizational programs, the Illinois Department of Public Health has served the public and Illinois physicians on a myriad of levels. Their documented history is related in this month's issue of *IMJ*. An awareness of their worth and appreciation of their contribution are well in order.

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MAKES

SENSE

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* Warning

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* Indications: When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hypokalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids).

Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

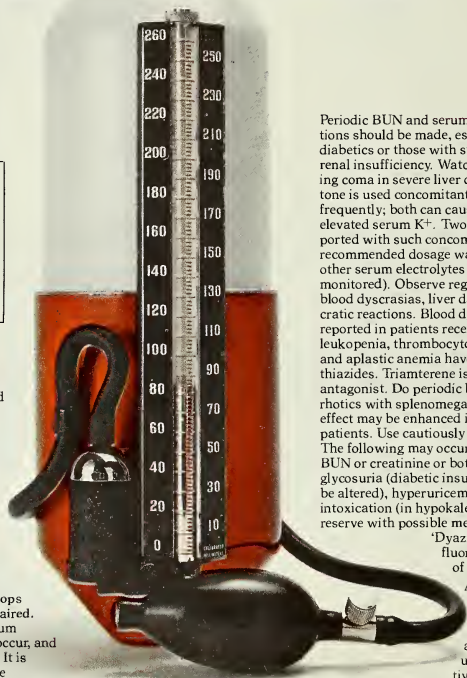
'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions:

Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions;

nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paronychia, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).



**FOR LONG-TERM CONTROL
OF HYPERTENSION*
SERUM K⁺ AND BUN SHOULD
BE CHECKED PERIODICALLY.
(SEE WARNINGS SECTION.)**

SK&F CO., Carolina, P.R. 00630

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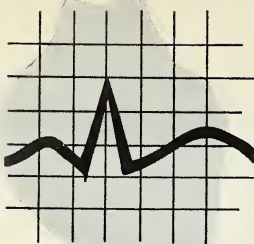
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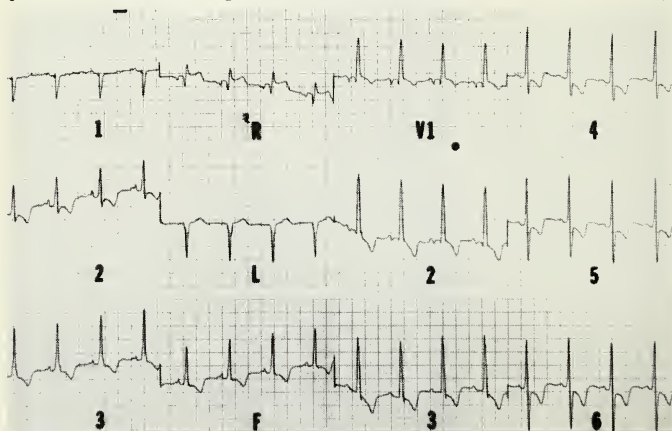
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ekg of the month

JOHN R. TOBIN, JR., M.S., M.D., RIMGAUDAS NEMICKAS, M.D.,
PATRICK J. SCANLON, M.D., JOHN F. MORAN, M.S., M.D.,
SARAH JOHNSON, M.D., and ROLF M. GUNNAR, M.S., M.D./
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

This is a fifty-five year old woman who presented with a two-year history of worsening exertional dyspnea and palpitations. She had been in pulmonary edema on one occasion which responded to digoxin and furosemide. Despite these medications, her symptoms continued and seemed to be gradually worsening. Her physical examination showed bilateral basal rales, a prominent left parasternal lift, a loud ventricular gallop (S_3), and a crescendo decrescendo systolic murmur heard all over the precordium. In addition, her liver seemed to be enlarged. Rheumatic mitral valvular disease was suspected. Cardiac catheterization was performed and showed a left to right shunt at the atrial level of nearly 5 to 1 pulmonary to systemic flow ratio. In addition the pulmonary artery pressure was 125/20 mmHg. The ECG was taken before the catheterization study.



Questions:

1. The ECG shows:

- A. Complete right bundle branch block.
- B. Severe right ventricular hypertrophy.
- C. Marked right axis deviation.
- D. Left atrial enlargement.
- E. All of the above.

2. The following statements are true:

- A. Most atrial septal defects are seen in females.
- B. The spectrum of pathology in atrial sep-

tal defect includes patent foramen ovale, persistent ostium secundum defect, sinus venosus defect, and endocardial cushion defects, *i.e.*, ostium primum defects and common AV canal.

- C. The most serious complication of atrial septal defect is the development of severe pulmonary hypertension.
- D. Chronic atrial fibrillation or atrial flutter are relatively common in older patients with atrial septal defect.
- E. All of the above.

(Continued on page 50)



IIMJ

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EPENDYMAL BRAIN CYST

By JOHN L. BENDER, M.D. AND JOHN H. VANLANDINGHAM, M.D./ROCKFORD

A 43-year-old white woman had a one month history of visual blurring and clumsiness of gait and was found to have a homonymous right inferior quadrantanopsia. Computerized cerebral tomogram revealed a left occipital lobe cystic lesion. Additional testing indicated no communication of the cyst with either the subarachnoid or ventricular spaces. Surgical exploration and biopsy revealed a neuroepithelial (ependymal) cyst treated by marsupialization. The most valuable diagnostic procedures for such a lesion were CCT scan and radioisotope cisternography.

Ependymal lined intracranial cysts occur infrequently in the parenchyma of the centrum semiovale.¹⁻⁵ Computerized cerebral tomography has recently been reported to be of value in diagnosing such lesions.⁵ The following patient had such a symptomatic occipital lobe cyst first discovered on computerized tomography.

Case Report

The patient was a 43-year-old white woman who began stumbling down stairs and also noted visual blurring at distances. She saw her ophthal-

mologist for possible corrective lens change, was discovered to have a homonymous field defect, and was referred for further neurological evaluation. The patient was also an obese diabetic under treatment with diet and DBI-TD 50mg daily. Past history revealed headaches several years before, which had cleared with medication. She had experienced no birth or later trauma and no infection of the nervous system.

Significant neurological findings were limited to the visual apparatus, V. A. 20/20, O. U., corrected. She had a congruous right homonymous inferior quadrantanopsia with macular sparing. Funduscopic examination, pupillary size, reactivity and eye movements were normal.

The patient was admitted to Rockford Memorial Hospital. CBC, serology, urinalysis, EKG, chest and skull X-rays were normal. Chemical screening revealed a uric acid of 9.2 mg%. Blood sugars ranged between 114-204 mg%. EEG using referential and bipolar montages revealed a background activity of 9½-10 cps with 6½-7 cps 50-150 microvolt slowing limited to the posterior left cerebral hemisphere. Computerized cerebral tomography revealed a large oval area of de-

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JOHN H. VAN LANDINGHAM, M.D., is a neurological surgeon practicing in Rockford. Doctor VanLandingham serves on the Regional Board for Comprehensive Health Planning of Northwest Illinois. He is also an assistant clinical professor of neurology and neurosurgery at the University of Illinois Rockford School of Medicine. Doctor VanLandingham is a member of both the Congress and the American Association of Neurological Surgeons.

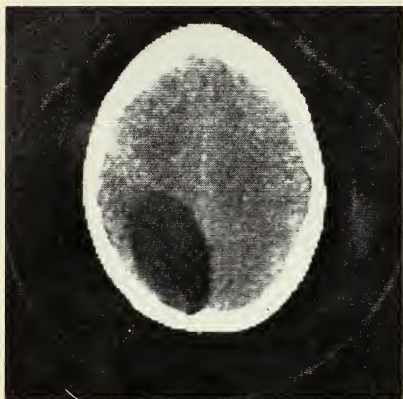


Figure 1
CCT showing the cyst in the left occipital lobe.

creased density in the left occipital lobe (Figure 1). Radionuclide brain scan was normal. Left percutaneous carotid angiography revealed draping of vessels over an avascular mass in the posterior parietal-occipital region without significant displacement of the Sylvian or anterior cerebral arteries. Pneumoencephalography was noted primarily for the absence of air over the left posterior cerebral convexity and without apparent communication between the cyst and either subarachnoid or ventricular spaces (Figure 2). Lumbar puncture revealed normal pressure and clear colorless fluid containing 5 lymphocytes/mm³ and protein of 30 mg%. Nucleide cisternography using 1 millicurie of Ytterbium 169 DTPA was performed with films taken at 24, 48, and 72 hours (Figure 3). The isotope failed to appear within the cyst, confirming the pneumoencephalographic findings of no communication with the subarachnoid and ventricular spaces.

A left occipital craniotomy was performed (JHV). The brain appeared full but not tense and was not adherent to the overlying meninges. Cannulation encountered the cyst 1 cm below the cortical surface from which pale yellow clear fluid was drained. The fluid contained 1 lymphocyte/mm³ and protein of 178 mg%. A transcortical incision was made over the thinnest portion of cyst wall, which was 5 mm below the cortical surface. The entire cyst was explored and was 6-7 cm in widest diameter and extended medially as far as the midline so that the falx cerebri



Figure 2
Pneumoencephalogram showing absence of air over the left posterior cerebral convexity and minimal left lateral ventricle displacement across the midline.

could be visualized through the translucent wall. Two thin membranous satellite cysts abutted on the main cyst and were also drained of a fluid similar in appearance. A biopsy of the cyst wall and overlying cerebral cortex was obtained. The patient's post-operative condition was unchanged. One week after surgery she developed expressive dysphasia and complete right homonymous hemianopsia. Repeat E.M.I. scan revealed reduced cyst size and left cerebral edema (Figure 4). A course of dexamethazone reversed these signs, and upon hospital dismissal the only abnormal neurological sign was the persisting homonymous right inferior quadrantanopsia. Repeated examinations have remained unchanged.

The biopsy material submitted for study (Figure 5) revealed the cyst wall to be lined with low cuboidal cells resembling ependyma.

Discussion

The first neuroepithelial (colloid) cyst of the third ventricle was reported in 1858 by Wallman.⁶ While neuroepithelial cysts occur most frequently in the third ventricle, they may be found in the nervous system wherever ependymal tissue is located.² Such ependymal cysts are in-

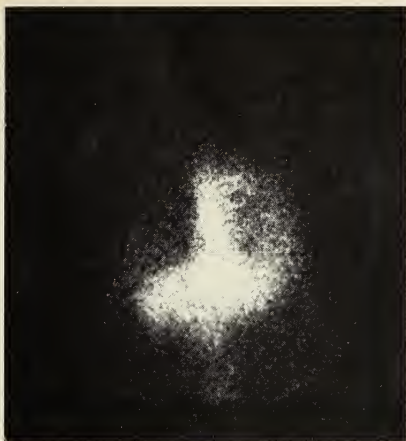


Figure 3A



Figure 3B

Figure 3

Radionuclide cisternography showing no radioactive material collecting in the subarachnoid space of the posterior left cerebral hemisphere nor in the cyst itself. (A) PA view. (B) Left lateral view.

frequently located within the parenchyma of the cerebral hemisphere.

In the second month the fetal nervous system is divided into internal ependymal, a middle mantle and an external marginal layer. The ependymal cells arise from primitive spongioblasts and can migrate peripherally. Ependymal cell tissue has been found in white matter.⁷ Weed⁸ found that primitive ependyma can excrete a high protein fluid before the choroid plexus is elaborated, so that ependymal cell rests are capable of cyst formation. Ependymal tissue is also capable of evagination, so that a portion of ventricle conceivably could be pinched off from the main body to form an isolated cyst.⁴

Since the cyst may contain either a low or high concentration of protein, this has been thought to be due to elaboration of a protein poor fluid whose water escapes to increase the concentration. At a critical point where the osmotic exceeds the hydrostatic pressure, the cyst would enlarge.⁷ Some neuroepithelial cysts are lined only by ependyma, while others also contain choroid plexus. We propose that if ependyma excretes a protein rich fluid and a protein depleted fluid is secreted only with the subsequent development of the choroid plexus,⁸ then

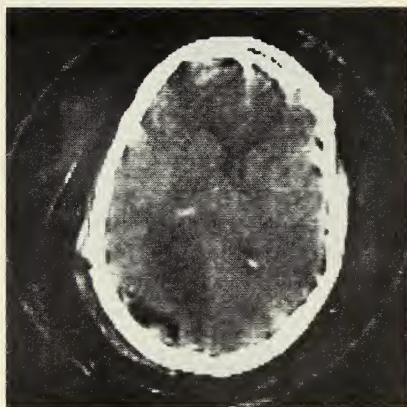


Figure 4

Postoperative CCT revealing reduced cyst size and cerebral edema with anterior ventricular shift towards the right.

the concentration of protein is dependent upon the percentage of choroid plexus present in the cyst wall.

Our patient is not unusual in developing symptoms in middle life.^{2-5,7} Others have assumed that these cysts gradually increase in size throughout life and that symptoms finally occur when the critical mass for that location is

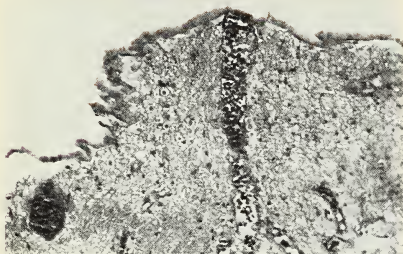


Figure 5A

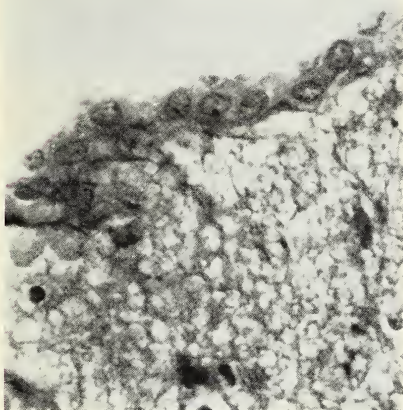


Figure 5B

Figure 5

Biopsy material revealing cyst cavity (above), ependymal lining and gliotic brain tissue. (A) Low power (B) High power.

reached. One might question such a concept and instead compare ependymal cyst formation to evolution of a tumor arising for primordial cell rests in later life. It would be necessary to hypothesize a triggering mechanism in both instances.

We agree with MacGregor⁵ that computerized cerebral tomography can identify such lesions. We found that isotope brain scanning, angiography and air contrast studies were of little or no value. However, radioisotope cisternography is of value to establish the absence of communi-

cation between the cyst and the subarachnoid and ventricular spaces. Thus, cisternography may help to differentiate ependymal cyst from leptomeningeal and porencephalic cyst. Marsupialization of the cyst prevents further enlargement, so that although the original symptoms may not regress, one should not expect additional signs and symptoms to later appear. ◀

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Health Care Survey of a Small Doctorless Community in Southeastern Illinois

By JIM MEDDER, M.D., MAX HAMMER, M.D., AND TOM HERRMAN, M.D./EVANSVILLE, INDIANA,
SPRINGFIELD AND DENVER, COLORADO

The Southern Illinois University School of Medicine was established with a goal of encouraging physicians to practice in communities of southern and central Illinois. Many doctorless communities in the area have been seeking prospective doctors to establish a practice. However, little is known concerning the health problems and needs of these small towns as well as their perceptions regarding their present health care systems. As part of a medical school research project, we have tried to characterize one small doctorless community with respect to its health care attitudes, needs, resources, and present utilization patterns.

Wayne City is an agricultural, doctorless community with a population of 1,000 in southeast-

ern Illinois (Wayne County). Like many similar communities, its citizens have actively sought a doctor since its only physician died seven years ago. The nearest doctors and hospitals are located in Fairfield, 12 miles away, and Mt. Vernon, 17 miles away. Present health care resources in the village include a pharmacist and a part-time dentist.

Methods

A survey instrument was developed to assess current medical habits and attitudes. The population consisted of the residents of Wayne City and the surrounding school district for that community, which represents approximately 4,000 persons. Two sampling methods were used. First, a questionnaire was distributed via the school system to children: each family with a child in school received a questionnaire to be returned to the school. There were 196 responses from the 500 questionnaires that were distributed, representing 838 people.

The second method was utilized to sample those households without children. Names were taken from voting lists for the last election; these households were known not to have children in school at the present time. Questionnaires with return postage paid envelopes were mailed to the heads of these households. One hundred seventeen responses were received from 480 questionnaires that were mailed; these responses represent 250 people. Approximately 75% of the households in the sampling area received our survey; the combined samples represent 1088 people of the 4,000 in this area.

Results

Biographic data of respondents indicate that 56% of the surveys were completed by women.

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Table 1
Yearly Incomes of Households

Income in Dollars	N	%
Less than 5,000	38	14.7
5,000-9,999	78	30.1
10,000-14,999	69	26.6
Over 15,000	74	28.6
	259	100.0

Table 2
Type of Insurance

	N	%
Work Plan	118	39.7
Blue Cross Blue Shield	61	20.5
Private	57	19.2
No Insurance	39	13.1
Medicare-Medicaid	16	5.4
Other Type	6	2.0
	297	99.9

Table 3
Location of Doctor's Office and Preferred Hospital

	Doctor's Office		Hospital	
	N	%	N	%
Mt. Vernon	116	43.9	149	52.3
Fairfield	110	41.7	89	31.2
Other	38	14.4	47	16.5
	264	100.0	285	100.0

Table 4
Cost per Office Visit

Cost in Dollars	N	%
Less than 5.00	7	2.4
5.00-9.99	158	55.2
10.00-14.99	85	29.7
15.00 and up	36	12.6
	286	99.9

Table 5
Number of Times to Doctor per year per Household

	N	%
0	8	2.8
1-5	121	42.6
6-10	90	31.7
11-15	40	14.1
Over 15	25	8.8
	284	100.0

Table 6
Length of Time Required to Reach the Doctor's Office

	N	%
Less than 15 min.	15	5.0
15-29 min.	172	57.0
30-59 min.	99	32.8
1-2 hours	13	4.3
Over 2 hours	3	1.0
	302	100.1

The average age of respondents was 44 years, ranging from 18 to 84. A grade school education was attained by 23.9%; 58.3% have had a high school education, and 17.8% have had some college education. Overall, there is an average of 3.5 persons per household and 92.6% of the households have no one except immediate family residing in their home. The average length of residence in the community is 31 years.

Income levels are shown in Table 1 and indicate that over half of the respondents have annual incomes in excess of \$10,000. The predominant type of insurance is a work plan, followed by Blue Cross-Blue Shield and private insurance, as shown in Table 2. Thirteen percent report having no insurance coverage.

The educational and income levels for Wayne County, from Illinois census data, are not as high as those in our survey. The percentage of high school graduates who are 25 years of age or older is 32.5% for males and 35.3% for females. The mean income for residents of Wayne County is \$7,967.¹ Furthermore, there are 2.79 persons per household according to census data.

Current Health Care Patterns

Current patterns of health care utilization show that 83.7% of the households have a regular doctor; of these, 88.5% were described as a general or family practitioner. Medical care for 51.3% of the families is obtained from a solo or partnership type of practice with the remainder receiving care from practices consisting of more than two doctors. The locations of the doctors are about equally divided between Fairfield and Mt. Vernon, but more respondents preferred Mt. Vernon hospitals to the hospital in Fairfield as shown in Table 3.

Information was gathered on various characteristics of office visits that had occurred during the preceding year. Table 4 indicates the cost per office visit; the average cost is \$9.65, ranging from \$2.00 to \$35.00. An average of 7.6 visits to the doctor occurred per household during the past year (Table 5). Three percent of the families did not visit a doctor during the preceding year, and 67.8% had not had a family member hospitalized during that time. The amount of

Table 7
Number of Days to Wait to Obtain an Appointment

Days	N	%
Same day	83	32.9
1	48	19.0
2-3	37	14.7
4-7	44	17.5
8-14	21	8.3
Over 14	19	7.5
	252	99.9

time required to reach a doctor is given in Table 6: 15 to 29 minutes for more than half of the families (this represents the driving distance to Mt. Vernon or Fairfield). The average waiting time for an appointment was 5.2 days although one-third received appointments for the same day on which they called, and one-fifth were given an appointment for the following day, as shown in Table 7. Waiting time in the doctor's office average 54 minutes and many waited for over an hour (Table 8).

Other Providers

Related to other health providers, the average family made 3.7 visits to the dentist last year; 18.9% did not go at all. Only 16.2% of the families use the part-time dentist while 54% utilize the pharmacist in Wayne City (Table 9). The optometrist received an average of 1.4 visits per household; 30.4% made no visits. 55.1% had never visited a chiropractor. Nineteen of 312

Table 8
Waiting Time in the Doctor's Office

Minutes	N	%
Less than 11	26	9.6
11-20	39	14.3
21-30	60	22.1
31-45	29	10.7
46-60	56	20.6
Over 60	62	22.8
	272	100.1

Table 9
Location of Pharmacist and Dentist

	Pharmacist		Dentist	
	N	%	N	%
Mt. Vernon	50	17.3	142	50.0
Fairfield	58	20.1	63	22.2
Wayne City	156	54.0	46	16.2
Other	25	8.7	33	11.6
	289	100.1	284	100.0

households had used the services of other personnel such as social workers, psychologists, and public health nurses. Only 16 households had a family member in a nursing home.

Several questions were posed to assess satisfaction with health care resources. As shown in Table 10, 70.1% of the respondents expressed satisfaction with their present medical care. 79.0% said they trusted and respected their doctor. However, 46.2% have changed doctors at some time in the past because of dissatisfaction with that doctor. In general, most responses re-

Table 10
Reactions to selected items from survey

	% Agree	% Disagree	% Uncertain	N
I'm very satisfied with the medical care I receive	70.1	10.2	19.7	274
I trust and respect my doctor	79.0	3.8	17.1	286
Most people are not encouraged to get a yearly exam when they go to the doctor	43.9	37.0	19.0	289
The fees doctors charge are too high	54.6	18.8	26.6	282
It's hard to get an appointment for medical care right away	45.3	45.6	9.1	285
There are enough family doctors around the community	2.4	89.9	7.7	286
Places where you can get medical care are conveniently located	54.1	36.6	9.3	279
In an emergency it's very hard to get medical help quickly	50.7	31.3	18.0	284
I spend a reasonable amount of time waiting in my doctor's office	64.7	26.5	8.8	283
My doctor is very careful to check everything when examining his patients	57.5	21.1	21.5	275
My doctor always tells his patients what to expect during treatment	62.1	22.5	15.4	285
My doctor seldom explains my illness to me	27.5	63.8	8.7	287
My doctor doesn't advise his patients about ways to avoid illness or injury	28.3	52.0	19.7	279
If I have a medical question, I can reach someone for help without any problems	45.7	34.9	19.4	289

fect a satisfaction with the doctors and medical care with the exceptions of preventive care (37% agreeing that they are encouraged to get yearly exams) and of the costs of office visits, which most agree are too high.

When asked if there were enough doctors in the area, 99.7% disagreed. And when asked if they would go to a doctor in Wayne City if there were one, 60.4% responded that they would take their entire family; another 22.5% would take part of their family. This indicates that four-fifths would give some support to a new doctor in their community.

Summary

The results of this questionnaire seem to be paradoxical in nature. Seventy percent of the respondents indicated that they are "very satisfied" with the medical care provided to them. At the same time, 50% feel that it is difficult to get help quickly in an emergency. Half of the respondents also feel that fees for medical services are too high, and nearly that many feel that it is difficult to get an appointment right away. The average waiting time in the doctor's office was found to be 54 minutes and yet approximately 65% of the respondents feel that the waiting time is reasonable!

This paradox between general satisfaction with medical care and the specific types of dissatisfaction may, in part, be explained by the fact that over 90% of the respondents feel that more family doctors are needed in the community. Given a general consensus regarding the doctor shortage problem, the people may be indicating that care is adequate under the circumstances. Waiting for an hour in the doctor's office may not seem unreasonable when the patient looks around and sees how many others are also waiting for the services of only one person. In fact, the people of this community may feel that satisfaction should be measured in terms of what is available and not in terms of the ideal in order to cope with their doctor shortage problem. ◀

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Acknowledgement

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Hand Elevation

A Simple Effective Method

BY ELVIN G. ZOOK, M.D., PAUL WAVAK, M.D., AND
JEFFREY N. METZMAKER, M.D./SPRINGFIELD AND WORCESTER, MASS.

Elevation of the extremity is one of the cardinal principles in the care of the infected or injured hand. Many methods, each with its own advantages and disadvantages, have been advocated over the years for achieving this elevation. The method presented here is simple, safe and, above all, effective.

A piece of common brown cotton stockinette two or four inches in diameter for infants and

children and four or six inches in diameter for adults is used. Unless the stockinette is going to be placed next to the open wound, sterility is not essential. A segment of stockinette measuring approximately seven feet in length is used for the adult. One end is divided longitudinally in half for approximately two feet and the opposite end is divided for approximately three feet. (Fig-

ELVIN G. ZOOK, M.D., is a professor and plastic surgeon affiliated with the Southern Illinois University School of Medicine in Springfield. A former diplomate of the American Boards of Surgery, Thoracic Surgery and Plastic Surgery, Doctor Zook serves as a consultant in plastic surgery for the Marion Veterans Administration Hospital in Marion, the Memorial Medical Center Burn Unit in Springfield, and the Cancer Information Service of the Illinois Cancer Council. Doctor Zook is a member of the medical staff of St. John's Hospital in Springfield and director of the Congenital Head and Neck Anomalies Clinic for the Southern Illinois University School of Medicine in Springfield.

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JEFFREY N. METZMAKER, M.D., is an orthopedic surgeon serving his residency at the University of Massachusetts program in Worcester, Massachusetts. At this writing, Doctor Metzmaker was completing a general surgical residency with the Southern Illinois University School of Medicine in Springfield.

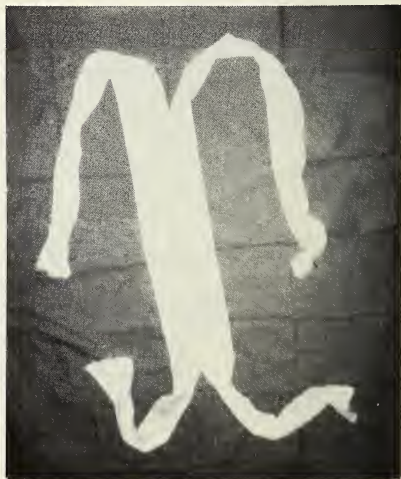


Figure 1

This is an example of the stockinette split at both ends with the shorter of the two ends to be tied around the trunk and the lower ends hung over the IV poles.

ure 1). The uncut portion of the stockinette is then rolled onto itself and slipped over the injured extremity with the short ends proximal. The short ends are then tied or pinned to each other around the neck or trunk, whichever is more comfortable for the patient. If both arms are to be elevated, the posterior ends may be tied or pinned together behind the back and the other ends anteriorly. The distal ends are then tied together and suspended from an IV pole. The split in the distal end may need to be ad-



Figure 2

The stockinette used to acutely elevate the upper extremity. If less elevation is desired, the elbow can be placed on a pillow or on the bed.

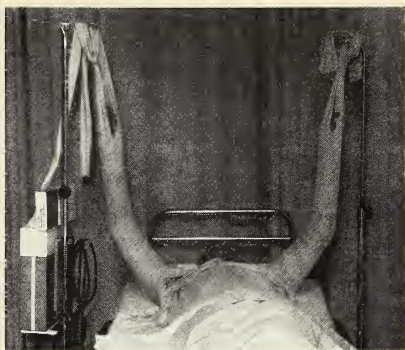


Figure 3

The stockinette used to elevate both arms acutely.

may be left resting on a pillow with the elbows flexed.

Discussion

Our experience has shown that each of the advocated methods for elevation of the upper extremity carries varying degrees of effectiveness, ease of implementation and possible complications. Elevation of the extremities on pillows, which is the most popular method, is undependable and works only as long as the patient is awake. Taping the arms to bed rails has been used but is uncomfortable because the patient has no latitude of motion and the method can serve as an unintended tourniquet. Skeletal traction with interosseous wiring has been advocated but infectious complications from the pin are inherent risks.

Elevation with stockinette as presented here is dependable in that the arm must stay elevated, the stockinette is elastic and eliminates the possibility of strangulation of the extremity with swelling, the split in the distal portion of the stockinette allows the fingers to be examined freely and the patient is comfortable with the maximum possible degree of motion in the bed or sitting in a chair. (Figure 2) It can also be used to elevate both arms and has been found to be an excellent method in bilateral hand burns since the stockinette can be autoclaved if the hands are to be left unbandaged. (Figure 3) Many patients who have had other forms of elevation have stated that this method is far more comfortable. ◀

justed so that the finger tips may be visualized intermittently. The arms may be suspended in acute elevation as in Figure 2, or the elbows

Clinics for Crippled Children Listed for August

Twenty-eight clinics for Illinois physically handicapped children have been scheduled for August by the University of Illinois, Division of Services for Crippled Children. The Division will count nineteen general clinics providing diagnostic, orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be eight special clinics for children with cardiac conditions and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- August 3 Hinsdale, Hinsdale Hospital
- August 4 Sterling, Community General Hospital
- August 4 Lake County Cardiac, Victory Memorial Hospital
- August 5 Division Cardiac, U. of I. at the Medical Center
- August 8 Peoria Cardiac, St. Francis Hospital
- August 9 E. St. Louis, Christian Welfare Hospital
- August 9 Peoria, St. Francis Hospital
- August 10 Champaign-Urbana, McKinley Hospital
- August 10 Joliet, St. Joseph's Hospital
- August 10 Rockford, St. Anthony's Hospital
- August 11 Springfield, St. John's Hospital
- August 11 Kankakee, St. Mary's Hospital
- August 12 Chicago Heights Cardiac, St. James Hospital
- August 15 Maywood, Loyola Medical Center
- August 16 Belleville, St. Elizabeth's Hospital
- August 16 Rock Island, Moline Public Hospital
- August 17 Springfield Pediatric Neurology—St. John's Hospital
- August 17 Chicago Heights General, St. James Hospital
- August 18 Rockford, Rockford Memorial Hospital
- August 18 Bloomington, Mennonite Hospital
- August 18 Elmhurst Cardiac, Memorial Hospital of DuPage County
- August 22 Peoria Cardiac, St. Francis Hospital
- August 23 Peoria, St. Francis Hospital
- August 23 Park Ridge Cardiac, Lutheran General Hospital
- August 24 Aurora, Sherman Hospital
- August 25 Litchfield, St. Francis Hospital
- August 26 Evanston, St. Francis Hospital
- August 26 Chicago Heights Cardiac, St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

Obituaries

***Boley, Michael Henry**, Chicago, died May 22 at the age of 74. Doctor Boley was a 1927 graduate of the Medical College of Wisconsin at Milwaukee.

***Bowers, Lewis L.**, Rockford, died May 23 at the age of 94. Doctor Bowers was a 1916 graduate of the Chicago Medical School.

***Burke, Edmund J.**, LaSalle, died May 27 at the age of 89. Doctor Burke was a 1913 graduate of Rush Medical College.

***Ehrhardt, Oliver Earl**, Springfield, died April 1 at the age of 79. Doctor Ehrhardt was a 1926 graduate of Washington University School of Medicine in St. Louis, Missouri.

***Grichter, Benjamin B.**, Albuquerque, New Mexico, formerly of Park Ridge, died April 28 at the age of 75. Doctor Grichter was a 1917 graduate of Rush Medical College.

***Laury, Charles M.**, Kansas, formerly of Chicago, died January 18 at the age of 91. Doctor Laury was a 1918 graduate of Northwestern University Medical School.

***Lieberthal, Eugene P.**, Chicago, died May 12 at the age of 81. Doctor Lieberthal was a 1922 graduate from Prussia, Germany.

***Pisani, Albert Louis**, Hinsdale, died June 15 at the age of 52. Doctor Pisani was a 1954 graduate of the Loyola University Stritch School of Medicine.

***Rappaport, Benjamin**, Wadsworth, died May 3 at the age of 85. Doctor Rappaport was a 1915 graduate of Rush Medical College.

**Indicates ISMS member.*

**Indicates member of the ISMS Fifty Year Club.*

Board of Trustees Position

At the June 4 meeting of the ISMS Board of Trustees, the Council on Social and Medical Services reported their findings on "autogenous urine immunization therapy" for allergy treatment. After a thorough review of available materials, the Council determined that insufficient evidence exists to prove the treatment effective. In response to these findings, the Board of Trustees has stated its formal opposition to the current use of "autogenous urine immunization therapy" for allergy treatment.

COMPLICATIONS OF COLONOSCOPY

By JAMES GRAHAM, M.D., AND ERNESTO B. EUSEBIO, M.D./SPRINGFIELD

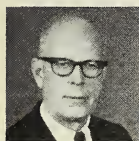
Colonoscopy is not without its risks of morbidity and mortality. The apparent simplicity of the procedure is deceptive. In the series of 742 colonoscopies and polypectomies reported here, there was an overall morbidity of 0.53% and no mortality. This experience parallels reported collective series. Chief among the complications are perforation, laceration (tearing), hemorrhage and obstruction. A service that offers colonoscopy must be prepared for laparotomy in case of perforation or uncontrolled hemorrhage.

Fiberoptic colonoscopy brings the mucosal lining of the cavernous and previously hidden colonic interior into full view for direct visual evaluations, biopsies, washings, photographs, and the removal of intraluminal lesions. This major advance in instrumentation overcomes the limitation of rigid sigmoidoscopy, complements radiographic examination of the colon and substantially reduces morbidity in removing a variety of colonic neoplasms.

Colonoscopy, however, is not without its com-

plications, most notably perforations, lacerations (tearings), hemorrhage and obstruction.

Experience with such complications on the Colon and Rectal Service at St. John's Hospital is tabulated in Figure 1. The overall morbidity, including lacerations and tears is 1.3% or 0.53% when tears are excluded. Lacerations, as listed here, generally are not included in the reported collected series.¹⁻³ There were no deaths in this series. Colonoscopic procedures on a surgical service such as those reported here are weighted toward surgical conditions. These occur more often in the left colon.



JAMES GRAHAM, M.D., is a clinical professor of surgery at the Southern Illinois University School of Medicine. A past president of the Sangamon County Medical Society, Dr. Graham specializes in colon and rectal surgery. He was a volunteer physician in Vietnam (AMA) in 1968, and is now a member of the executive committee of the Western Illinois Comprehensive Health Systems Agency.



ERNESTO B. EUSEBIO, M.D., is a clinical associate in surgery for the SIU Medical School in Springfield. He is also an associate staff member of St. John's Hospital and Memorial Medical Center in Springfield, as well as an active staff member at Springfield Community Hospital.

Figure 1
Tabulation of Complications

Perforations		3
Diagnostic	2	
Polypectomy	1	
Lacerations		6
Hemorrhage		0
Obstruction		1
Uncomplicated		
(Diagnostic)		615
Uncomplicated		
(Polypectomy)		117
Total		742

Members of the American Society of Gastrointestinal Endoscopists reported 25,298 diagnostic colonoscopies with a morbidity of 0.32% and a mortality of 0.008%. The most common complication of diagnostic colonoscopy was perforation (55 cases or 0.22%). There were two fatalities, both of them associated with perforation.

There were 6,214 colonoscopic polypectomies with a morbidity of 2.3% and no mortality. The most common complication of polypectomy was hemorrhage, 115 cases or 1.9%.

Perforations

The first "diagnostic" perforation in this series was associated with diverticular disease. In this condition, advancement of a colonoscope through the narrowed lumen of the sigmoid can be a formidable task when muscular thickening in the colonic wall has gathered the mucosa into stiff, accordion-pleated folds. The adhesions of peridiverticulitis frequently lock one or more twisted loops of sigmoid in the pelvis, binding the serosa to other pelvic organs and to the pelvic peritoneum, a circumstance readily appreciated by abdominal surgeons who are familiar with the difficulties of "digging" and maneuvering a diverticular sigmoid out of the pelvis. A double coil formed by the colonoscope in these instances is almost pathognomonic of diverticular disease (Figure 2).

The perforation in this case was recognized immediately and confirmed by evidence of free air on a scout X-ray film. At laparotomy the section of colon involved in the diverticular process was

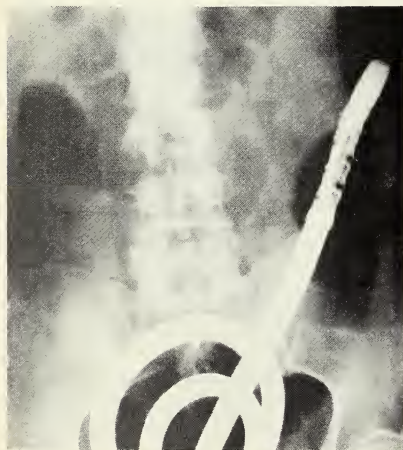


Figure 2

Fixed, doubly coiled sigmoid almost pathognomonic of diverticular disease. Colonoscope, in this single X-ray view, falsely appears to be outside of the colonic lumen.

removed. Although a temporary colostomy was required, the patient made a complete recovery.

This perforation was among the first 100 procedures in the series and occurred prior to the time fluoroscopic control was available as a routine measure. The incident reflects the generally reported outcome that these kinds of complications are reduced as experience grows and when radiographic control is at hand.

The second "diagnostic" perforation occurred in a male patient who had carcinoma of the sigmoid. This perforation, likewise, was recognized and confirmed immediately. Laparotomy revealed a perforation in the mid-sigmoid at the distal edge of the carcinoma. The colon was adherent to the lateral pelvic wall in a sharply angulated configuration. The patient had metastatic disease. Because of this the sigmoid was brought out as a colostomy without definitive resection. He was dismissed from the hospital in temporarily good condition.

Perforations are the result either of direct penetration of the colonic wall by the colonoscope or of bursting of a thin and weakened coagulated spot in the wall during or following polypectomy. Inflation of the colon, which is necessary accompaniment of colonoscopy, stretches the wall and thus predisposes to perforation.

The "polypectomy" perforation in this series was delayed 24 hours. The patient experienced moderate abdominal pain, slow in onset. A scout X-ray film showed free air. At laparotomy a pin-size hole was closed by suture and the area was covered with a tab of fat.

Patients are kept in the hospital overnight after polypectomy and are cautioned that perforation is a possibility during the following week. Shinya and Wolff⁴ stress that the apparent simplicity of colonoscopic polypectomy is deceptive. They perform polypectomy in either the ambulatory or the hospitalized patient. Their basic considerations are the size and nature of the polyp, the patient's general condition and the preference of the operator. One must be fully prepared to undertake laparotomy for perforation or hemorrhage.

Lacerations

Six lacerations are listed. These are tears or splits either of the seromuscular layers of the bowel, without submucosal dehiscence, or of the mesentery. Three of these tears were confirmed during laparotomies that were performed for definitive surgery several days after colonoscopy. In one patient the split in the bowel wall mea-

sured two cm and extended longitudinally along the antimesenteric surface. In a second instance, there were three closely approximated longitudinal tears of one cm each, associated with a 1.5 cm split in the mesentery. A single mesenteric tear in a third patient measured 2 cm. In none of these instances was there free blood in the peritoneal cavity or evidence of significant inflammatory reaction.

Two of the patients whose lacerations had been confirmed at a later elective laparotomy had experienced abdominal discomfort and had shown distention with diminished bowel sounds after colonoscopy. The third of these patients had been asymptomatic.

Three patients listed as having had lacerations but with unconfirmed diagnoses had abdominal discomfort and distention for several days after colonoscopy. It was assumed that their symptoms were caused by lacerations or tears such as had been observed at laparotomy. The incidents were listed, therefore, as lacerations. The symptoms could have been produced by minute perforations sealed by adherent fat. Overholt *et al.*⁵ reported an instance of silent perforation evidenced by localized and adherent inflammatory reaction at later laparotomy.

Livstone and Kerstein,⁶ in their report of a patient with a perforation and laceration, speculated on the mechanism that leads to lacerations. Presumably, these complications arise from a combination of wide and rapid distention of the bowel by insufflated air⁷ and of linear stretching of the bowel and mesentery as the colonoscope bows into a larger and larger arc when the forward movement of the tip of the instrument lags behind the rate of insertion into the rectum. This bowing phenomenon can be overcome by means of a relatively inflexible overtube ("stiffener") that is slid over the colonoscope and into the rectum and sigmoid (Figure 3). Application of the overtube requires skill, patience and radiographic control.

The spleen can be torn similarly when the splenic flexure of the colon is adherent to the periphery of the spleen.³ Retroperitoneal emphysema may appear as another manifestation of the same mechanism.^{8,9} This complication is benign and improvement is rapid.

Hemorrhage

Hemorrhage was not a complication in this series. In one of the polypectomies it was necessary to re-lasso the stalk to control a slow dripping of blood. The endoscopist is torn between



Figure 3
Good question mark configuration of colon obtained by straightening sigmoid with overtube that is distinguished on the right by its crenelated appearance.

too thorough coagulation of the stalk that might extend to and weaken the colonic wall on one hand, and insufficient coagulation that does not seal the stalk artery tightly enough on the other hand.

Endoscopists differ in their use of electrocurrent.³ Some prefer cutting current, some prefer coagulation. Still others select a combination or blend of coagulation and cutting currents. The combination method has been applied in the series reported here. Coagulation has been used in short bursts of a few seconds, increasing the intensity if necessary, until discoloration of the stalk becomes apparent. At this point, slight tension is applied and the stalk is severed with cutting current.

Hemorrhage (bleeding of significance) is associated only with polypectomy. It has not been reported as a serious problem in other situations. In a collected series of 3850 colonoscopic procedures performed by members of the Southern California Society of Gastrointestinal Endoscopists,¹ a series that reflects generally the reported experiences in the United States, six of 901 polypectomized patients were listed as "bleeding" (0.66%). Two patients in the California series had two units of blood each, two patients re-

quired only electrolyte solutions intravenously. One patient needed laparotomy. One recovered with observation only.

Obstruction

The obstruction listed in the tabulation (Figure 1) occurred in the sigmoid colon. Colon X-rays that were taken because of repeated attacks of left lower quadrant pain showed extensive sigmoid diverticular disease with deformity of a questionable nature. Colonoscopic examination revealed a sessile, polypoid lesion of 1.5 cm in addition to a stiff, fixed, twisted and narrow sigmoid. On the following day the patient's abdomen became distended and he was unable to expel flatus. X-ray examination showed distention of the colon proximal to the sigmoid. During preparation for surgery the patient vomited and aspirated some vomitus. His temperature rose to 39.0°C. Chest X-ray showed bilateral pneumonitis. Because of the circumstances surgical relief of the obstruction was limited to transverse colostomy. Later, the sigmoid colon was removed (the neoplasm was benign) and the colostomy was closed. The patient recovered.

The obstruction, incipient and partial to begin with, was precipitated and rendered complete by the edema and bloody extravasation that were consequences of trauma from colonoscopic manipulation.

Explosions

Explosive gases, hydrogen and methane, are produced in the colon by bacteria. Explosion of these gases in the presence of oxygen and an electric spark can be prevented either by intensive preoperative preparation that will free the colon completely of all feces¹⁰ or by the use of carbon dioxide or nitrogen gas for insufflation.³ Practice differs depending upon judgment about the ability to clear the bowel effectively. Some endoscopists use the inert gases entirely for insufflation, some use these gases only at the time of polypectomy. Some use room air throughout all procedures.

In this series there were no explosions. Carbon dioxide was used both ways, either throughout a procedure or only at the time of polypectomy, depending upon which make of instrument was being used. ◀

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Viewbox

(Continued from page 20)

Diagnosis: Mediastinal fat accumulation.

The appearance of the superior mediastinum suggests a mass which widens the mediastinum and demonstrates poorly defined masses which appear somewhat flat in character. The mass does not appear as dense as one would anticipate a mediastinal mass to be. The trachea is not compressed by this mass. The examination is consistent with a fat accumulation common in patients with primary Cushing's disease.

This radiographic appearance of mediastinal fat was first noted in patients who had received long term steroid therapy. Some of these cases were confirmed at surgery and post mortem. Cases of Cushing's disease have been reported with similar radiographic changes in the mediastinum. It is important to recognize this condition in order to avoid clinically insignificant surgery or biopsy. A more precise noninvasive method of diagnosis would utilize a mediastinal CAT scan to identify the material as one of fatty density.

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The Illinois Department of Public Health — 1877-1977

BY MARY A. HUCK, PUBLIC INFORMATION OFFICER, IDPH/SPRINGFIELD

The state department of public health had its official beginning in Illinois on July 12, 1877. On July 1 of that year, two laws became effective. These laws, one known as the State Board of Health Act, and the other as the Medical Practice Act, had the same purpose: the regulation of the practice of medicine and the promotion of sanitary and hygienic activities. The State Board of Health was charged with the responsibilities and duties involved in the enforcement of both. This dual responsibility was new for a state board of health in the United States, and it provoked considerable interest among sanitarians and the medical profession throughout the country.

The passage of these two public health laws was not an expression of a sudden burst of enthusiasm for more healthful conditions. It was, rather, the belated fruition of an idea that took root in territorial days some 60 years earlier, when an ordinance regulating the practice of medicine was enacted by the Territorial General Assembly. Furthermore, the first State General Assembly passed a Medical Practice Act in 1819, and another was passed by the General Assembly in 1825. The ordinances provoked agitation among the people of Illinois, especially the medical profession, and were promptly repealed by succeeding legislatures.

Formation of Local Health Agencies

The first local board of health in Illinois had been formed in Quincy in 1833, when a cholera epidemic hit that city. According to accounts published at the time in the Quincy Herald-Whig, "The first health board in Illinois—perhaps in the middle west—was born of desperation. The prompt measures taken by the Board brought results. Householders were ordered to dispose of rubbish and garbage, to clean their houses and grounds, to boil drinking water. The sheriff was ordered to scrub the jail. The Board used lime liberally. Most difficult were the burials in the new cemetery. People couldn't be per-

suaded to touch the victims, and the Board conducted most burials, even digging the graves."

This first Board was faced with a problem often faced by public health agencies today: a shortage of funds. Although citizens of Quincy demanded formation of the Board at a mass meeting, there were no village funds to support it. Accordingly, the Board members solicited contributions and collected the impressive sum of \$26.95!

In Chicago, where a Board of Health had been established to meet the threat of a cholera epidemic, that Board was abolished in 1860, "on account of the absence of any alarming condition." It was re-established in 1867, however, when cholera hit the city and smallpox was reaching epidemic proportions.

Creation of State Board of Health

This, then, was the climate into which the State Board of Health was born, with a staff of three persons and a two-year budget of \$5,000, plus \$1,000 for contingencies.

The idea of public health service, as it was finally expressed in the first permanent statutes, grew out of two very definite and distinct concepts. One was that good physicians are the dominant factor necessary to good public health. The other was that the application of sanitation, quarantine and hygiene will produce significant results in preserving and improving public health beyond the capacity of private medical practitioners.

These two concepts did not always promote harmony of action.

Proponents of the "good doctors" concept knew exactly what they wanted, and were instrumental in the passage of a Medical Practice Act which was very definitive and specific.

Advocates of sanitation, on the other hand, had little of a tangible nature which they could recommend in language that the average legislator could understand.

Accordingly, the first public health law grant-

ed the State Board of Health the "general supervision of the interests of the health and life of the citizens of the State" and the "authority to make such rules and regulations, and such sanitary investigations as they from time to time may deem necessary for the preservation or improvement of public health."

This sweeping authority was a recognition by the legislature that public health work is highly technical and requires specially trained personnel. The lawmakers have never retracted from this position.

The development of the Illinois Department of Public Health falls conveniently into six rather well-defined periods.

Period of Probation

The first period (1877-1900) may be described as a probationary experience for the State Board of Health. During that time, the state health organization faced the problem of justifying its existence. Governors and lawmakers allowed it to continue in an attitude of kindly tolerance. They were never sufficiently enthused to unlock the treasury vaults for the benefit of this new venture. The appropriation for the State Board of Health rose from its initial \$5,000 for a biennium to \$9,250 for the last fiscal year of the century. Although a contingency fund of \$10,000 was available to draw on under specific circumstances, those conditions rarely arose—at least not in the opinion of the Governor, whose judgment was a lock on the purse strings.

The Secretary of the Board of Health, however, did not intend to allow a lack of funding to stand in the way of public health programs. He enlisted the assistance of inter-state and national agencies in an effort to prevent the introduction of diseases from outside the United States. At the same time, he vigorously promoted sanitary activities within the borders of Illinois.

In 1878, the Board adopted a form for use in making sanitary surveys through local people, in order to obtain the necessary information for defined areas of need. The Board sought a basis to improve the sanitation of any city in the state. Although response to the idea was disappointing at first, the concept began to grow until, during 1885, more than 300,000 inspections were made in 395 municipalities in 96 of the state's 102 counties.

The inspection report forms provided the Board of Health with detailed records of the environmental conditions for more than 300,000 premises, as well as local epidemics and family

health histories. Thus, the Board was able to activate hundreds of local people who put the state's health machinery into immediate touch with practically every household in Illinois.

Further Early Innovations

On November 22, 1881, the Board passed a resolution requiring that no pupil would be admitted to any public school in the state without presenting satisfactory evidence of proper and successful vaccination against smallpox. Nearly 500 persons worked to make the program successful, including attending physicians, municipal and county officials and school teachers. By January 24 of 1882, 510,517 vaccinations and revaccinations had been administered to public school children and to inmates of public institutions, private and parochial schools, colleges and academies. Within 60 days the smallpox immunization level of school children had risen from 45 to 94 percent!

The Board's attempts to justify its existence are clearly evident in the State Board of Health's first annual report. In 1877, an estimated 3,600 non-medical school graduates were practicing medicine in Illinois. The progress of the Board in ridding the state of unqualified medical practitioners was documented in the first annual report, covering the period from July, 1877, to December 31, 1878. The Board reported that, of the 3,600 non-graduates, about 1,400 of them had left the state or quit practice by the end of 1878. In recounting the status of the remaining 2,200 "non-graduates", the Board reported: "Three hundred graduated from medical schools in 1878; 150 have been examined by the Board for license to practice; 950 have received certificates of practice; 61 are awaiting examination; 350 have filed affidavits which are now being investigated at this office; 100 are practicing under preceptors; 150 practitioners are now attending the medical schools as students, with a view of graduating; and 150 are evading every provision of the law."

In this first annual report, the Board also reported on actions taken against "diploma-shops." The report is written with an eloquence of language, including a sprinkling of Shakespearian phraseology not found in today's official reports: "As nearly as can be ascertained, about 400 diplomas were held in this state by parties who had either bought them directly, or obtained them upon a nominal examination. Parties that we can name have such diplomas with grand gold medals of honor for distinguished attain-

ments in medical knowledge, both diplomas and medals having been obtained by direct purchase. The diplomas of nine medical colleges have not been recognized, owing to the fact that the Board had positive knowledge that they sold their diplomas.

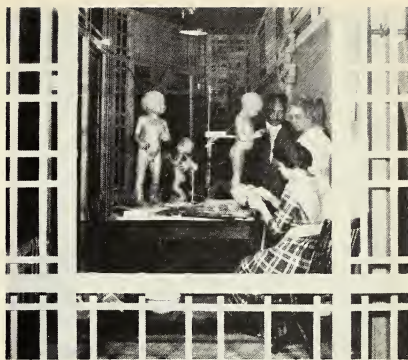
"Nearly all the vilest professional mountebanks, and the advertising specialists, quacks and abortionists that have hitherto traveled through this state from town to town, promising to cure all the ailments that flesh is heir to, have as a rule, been armed with diplomas of this character, which have been beautifully gotten up to assist in deluding an unsophisticated public. As works of art they are more imposing and exceed in style the diplomas of those institutions at which it is an honor to graduate."

In this section of the report, the Board members could not resist giving themselves a pat on the back by commenting, "the Board has accomplished more in breaking up this nefarious traffic than any other agency has been able to do." During this 18-month reporting period, the Board issued certificates to 4,950 physicians and 424 midwives.

A comment on advertising reads: "The Board does not object to legitimate, or in other words honest advertising; but when doctors pretend that they can cure everything, and advertise the same, the Board necessarily feels in duty bound, owing to its relations to the people and to honest medical men, to suppress the same. Much injury has been done by the tolerance of these quacks through the medium of the newspapers, by the false hopes held out of cure, not realizing that death awaits all."

Period of Expansion and Recognition: 1900-1917

The second period was one of expansion and recognition. In 1901, the legislature appropriated a sum of \$45,300 per annum for expenditure through the State Board of Health. For the fiscal year ending June 30, 1917, the available appropriation amounted to \$166,589. Evidently the people of Illinois and the legislature had found, in the State Board of Health, something for which they were willing to pay considerably more than had been the case 25 years before. The 1901 appropriation amounted to \$9 per 1,000 persons per year. By fiscal year 1917, it amounted to nearly \$25 per 1,000 persons annually. (In fiscal year 1977, the Department's combined state and federal funding amounted to \$5,304 per 1,000 persons.)



Education was among the primary goals of IDPH from the outset. Family health needs have been facilitated through the Department at a number of levels.

Appropriations listed on a nine-month audit report conducted in 1916 included these: \$110 for cadavers; \$150 for advertising; \$329.25 for ice water and sundries (only \$112.20 of this amount was spent); and \$300 car fare for lodging house inspectors (of which \$0.85 was spent during the nine months!)

Among other expenditures was \$72.98 traveling expense for an epidemiologist (\$2,000 had been appropriated for this purpose).

Salary appropriations included: \$3,600 for the Secretary (Director), \$8,846.28 for four clerks, \$3,000 for the Chief Sanitary Engineer, \$1,125 for the Registrar of Vital Statistics, \$2,400 for an Epidemiologist, \$2,500 for an Attorney, \$1,125 for the Chief Dairy Inspector, \$6,750 for two Health Officers.

Postage and telegraph/telephone services were important items, with a total appropriation of \$4,308.55. \$36.70 was spent on "electric lamps and connections" while \$10.50 was expended for "typewriters, machine fans, etc."

First Illinois Vital Statistics Act: 1915

The Vital Statistics Act, which became effective on January 1 of 1916, required that all reports of births, stillbirths and deaths be made within 10 days to the local registrar of vital statistics; and that all original certificates received during the month be forwarded to the State Department of Public Health in Springfield by the tenth of the following month.

By designating the Department of Public

Health as the central registration point for all original birth and death records, the Vital Statistics Act paved the way for the development of a uniform system of collection and transmission of information.

Passage of this Act followed several unsuccessful attempts at regulating birth and death records, and brought to an end the haphazard and indifferent way in which these records were frequently handled.

Period of Maturity

The third period (1917-1930) began with the adoption of the Civil Administrative Code by the Illinois state government. This period is called the period of maturity, in the sense that the Department of Public Health became regarded as an essential factor in state government, and began to function on a plane commensurate with that of any other department.

The adoption of the Civil Administrative Code in 1917 converted the State Board of Health into two departments. One of these was established for the purpose of sanitary and hygienic work alone. The other was charged with the handling of all matters relating to the licensure not only of physicians, but also all other professions which required it.

Thus the divorcement of the "good doctors" from the "sanitation and hygiene" concept came about. Both continued to be important activities of the state administration, but all matters relating to the registration of physicians and the regulation of medical practice were transferred to the Department of Registration and Education, while matters of sanitation, hygiene and vital statistics remained in the hands of the De-

partment of Public Health.

This new State Department of Public Health fell heir to all the public health duties, powers and responsibilities formerly vested in the State Board of Health, and had new ones added.

Responsibility for policies, rules and regulations was transferred from a board of seven members to one person, the Director of the Department.

A new contingency developed when the United States became embroiled in World War I, just a few months before the new health program was scheduled to begin. Thus the State Department of Public Health found itself, under wartime pressure, functioning quite differently than had been anticipated.

Instead of going deliberately into local communities, making contact with local officials, investigating water and sewer systems, promoting birth and death registration, stimulating close observance of quarantine and encouraging the establishment of efficient local health organizations, the field staff was largely concentrated in the immediate vicinity of military camps and busily engaged in handling emergency problems there.

Two other events which modified both the course of public health service and the function of its machinery were the 1916-17 outbreak of poliomyelitis and the wartime program against venereal diseases.

If the war frustrated the carefully devised public health program in Illinois, it also produced compensation. Members of the armed forces, subject to rigid military discipline, were vaccinated against smallpox and typhoid fever. The civilian population, subject to unusual demands, developed a mental attitude that facilitated practical application of official dictates. Health was recognized as a predominant factor in the success of the war effort.

On September 21, 1918, the pandemic of influenza which encircled the globe reached Chicago. It attained its maximum on October 17 when 381 deaths from pneumonia and influenza occurred in a single day. The death rate from all causes fell to normal again during the week ending November 23, but by that time 8,510 Chicagoans had died from influenza and pneumonia.

Vigorous measures were taken to combat this epidemic. Influenza was made reportable. Public funerals were prohibited. Smoking and spitting on the street and on elevated railroad cars were prohibited. Theatres, skating rinks, night schools and lodge halls were closed on October 15 and kept closed for 15 days.



Public health clinics across the state facilitate education and disease prevention. Immunization and perinatal care programs are among the many services they provide.

A mixed vaccine was prepared under the auspices of a laboratory committee, and a total of 313,028 doses had been distributed by January 1, 1919.

In the post-war era, the Illinois General Assembly looked with greater favor upon public health programs. Appropriations were increased each biennium. More public health programs were instituted. By the end of the 1920's, the State Department of Public Health had become a well rounded, unified organization providing a broad range of health services to the people of Illinois.

1930-1945: Period of Crises

The fourth period might very properly be termed a period of crises. During the Great Depression of the 1930's, and then during World War II, the Department faced many contingent special public health needs.

In 1930, a withering drought in the middle west devastated crops and pastures of 40 southern Illinois counties, complicating enormously the terrible effects of unemployment, poverty and misery brought on by the depression.

Polio, which had been almost quiescent in the state for nearly a decade (only 82 reported cases in 1929) turned sharply upward in 1930, with 402 cases. Reported cases of this disease reached a new high for Illinois in 1931, when 700 cases were reported.

The mainstream of public health problems in this period, however, was associated with the economic depression and the drought-stricken area of southern Illinois. With no legal authority and no funds for providing direct relief, the Department of Public Health intensified its efforts on the prevention of diseases along established lines: vaccination against smallpox, immunization against diphtheria, sanitation of water and milk supplies and the promotion of adequate low-cost diets.

Response to Second World War

By the time the United States entered World War II, the financial resources of the Department of Public Health were nearly three times higher than in 1930. Its legal responsibilities had been greatly broadened by new legislation.

The onset of the war in December of 1941 brought about a sudden change in the economy. A labor surplus shifted almost overnight to a labor shortage. Competition for professional and technical personnel was particularly keen in both



State-funded vaccinations have drastically reduced the fatality rate of communicable disease.

government and private enterprise. In the Department of Public Health, this situation led to an enormous personnel turnover on the one hand, and demands for new services on the other. Before the war was over, the Department lost 130 employees to the military, mostly engineers, nurses and physicians. The technical staff was nearly depleted.

At the same time, the Department intensified efforts along traditional public health lines, concentrated work in 19 areas of special military importance and undertook a number of temporary, war emergency projects. Among these were: an Emergency Maternity and Infant Care program for the wives and babies of men in the lower ranks of the armed forces, a corrective medical care program for young people rejected for military duty because of physical defects, an "emergency water corps" to protect local water supplies in the event of disaster or sabotage, volunteer first aid, home nursing, nutrition and emergency sanitation instruction and a blood-collecting program for emergency needs in the civilian population.

Period of Challenge

The fifth period, (1945-1960) might be called a period of challenge.

The extensive regulatory authority vested in the Department during the war years caused considerable change in the character of its work, making professional and technical expertise more important than mere numbers. Through

legislation, reorganization and the adoption of new procedures and techniques, together with an extensive personnel training program, the Department of Public Health entered the post-war era prepared to face the challenge of an emerging technological society.

The immediate post-war years were marked by (1) technological advancements which caused a rapid increase in both the opportunity and demand for more and better public health protection; (2) the emergence of an economy of abundance which made financing possible; (3) the almost sudden assumption by the state of long-neglected obligations as to public health; and (4) the accelerated participation of the federal government in the state's public health program.

Increased Federal Participation

Biennium	1941-1943	1951-1953	1959-1961
State			
Money	\$2,263,921	\$17,673,758	\$19,481,601
Federal			
Money	2,245,158	8,251,867	15,403,552
	\$4,509,072	\$25,925,625	\$34,885,153

(In Fiscal Year 1977, the Department's budget included \$38,184,200 in state money, and \$36,828,200 federal money.)

The complexion of the Department changed substantially between 1945 and 1960. Regulatory responsibilities, such as the licensing of various institutions and attention to environmental health, increased enormously. During this period, a considerable body of constructive public health legislation was enacted. Included among those subject to administration by the Department of Public Health were:

- The Nursing Home Licensing Act (1945)
- The Hospital Construction Act (1947)
- State Tuberculosis Sanitarium Act (1947)
- Public Water Supplies Act (1951)
- Hospital Licensing Act (1953)
- Trailer Coach Parks Licensing Act (1953)
- The Grade A Milk Law (1955)
- Anti-Poliomyelitis Vaccine Law (1955)
- Radiation Installation Registration Act (1957)
- Plumbing Code Act (1956)
- Radiation Protection Act (1959)
- Toxicological Laboratory Service Act (1959)
- Uniform Hazardous Substance Labeling Act (1959)
- Vital Statistics Act (1961)
- Migrant Labor Camp Licensing Act (1961)



Community health care concerns have encouraged an expanded concept of preventative medicine. Neighborhood swimming pools, frequent sites for the spread of disease, are now regulated under IDPH supervision.

Functions of the Department became more and more supervisory in character. The Public Health program had reached, or was approaching, the goals it had been originally designed to achieve: suppression of epidemic and infectious disease. Cholera and yellow fever had long been banished from Illinois. Malaria was gone. No cases of smallpox had been recorded since 1947. Diphtheria and polio were all but eliminated. Tuberculosis was but a shadow of what it once had been. All-in-all, communicable diseases in general were under control to a much greater degree than ever before. Immunizing agents against measles, rubella and mumps as well as polio vaccine made preventive health practices more available than ever before.

Period of Adjustment

The sixth period, which began in 1960 and continues to the present, can very properly be termed a period of adjustment.

Modern technology and scientific advances

that brought about favorable health conditions of the post-war era also created new public health problems. Many more people were surviving through middle-life and beyond. The aging process brought with it an immense problem of chronic and disabling ailments, including arthritis, heart disease, cancer and diabetes. The mushroom growth of the nursing home industry and the unprecedented demands on hospitals necessitated a new phase of public health. The challenge to the Department was to tackle the health problems of a technological society as vigorously as it tackled communicable diseases in 1877.

The advent of the nuclear age brought with it the construction of nuclear power plants in the state, and the concomitant necessity to monitor the air, water and land for contamination by radioactive substances.

Medical services for the poor became established programs.

The time had come in public health to shift gears, to reorient the line of advance, to change program emphasis, and adjust organization and services to a newly developed situation. It was a time for relentless vigilance, not only to maintain the ground gained against communicable diseases, but also to press forward against the changing health needs of today's world.

In 1920, E. E. A. Winslow, one of the most forceful advocates of the broad view of public health, crystallized his thoughts into what has become, and remains, the most widely accepted definition of public health and its relationship to other fields:

Public Health is the science and art of (1) preventing disease; (2) prolonging life; and (3) promoting health and efficiency through organized community effort for

- the sanitation of the environment***
- the control of communicable infections***
- the education of the individual in personal hygiene***
- the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and***
- the development of the social machinery to insure everyone a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birthright of health and longevity.***

The perimeters of public health concern have been moving outward at a rapid rate during the past few decades. Whereas public health matters

in the past focused on general sanitation, today all aspects of Winslow's famous definition are not only included, but surpassed.

With reference to the environment of man, the Department of Public Health now thinks in the broadest possible terms: the ecologic relationship between man and his environment. Similarly, with reference to personal health services, the Department is already deeply involved not only in problems of distribution of facilities and manpower, but also in their quality standards and in providing more and better care.

Public health is no longer content to conduct only those activities that place particular emphasis on the elimination of sanitary nuisances. This type of activity must continue, of course, but today's public health programs must embrace the total health needs of all people.

Current Activities and Future Plans

In order to meet this challenge, the Illinois Department of Public Health today employs some 1,100 professional, administrative, technical and clerical workers who are engaged in providing a broad range of services which protect the health and welfare of the more than 11 million residents of the state.

The Department administers or supports more than a hundred different services, and administers an annual budget of more than \$70 million of state and federal money. There is hardly an area of human activity with which the Department's family of programs is not concerned.

As it crosses the threshold into its second century, the Department of Public Health is involved in the daily lives of Illinois residents who drink milk, eat in restaurants, swim in public pools, drink from public water supplies, have dental or medical X-rays, shop for groceries, get married, divorced or have babies, shop for toys, send their children to summer camp, need eyeglasses, visit Illinois recreational areas, and engage in a myriad of other ordinary activities.

The Department also serves those who have special health needs, such as premature babies, children who need immunizations, persons who contract venereal diseases, victims of chronic renal disease, hemophilia, lead poisoning or hypertension, visitors to the State Fair, those who purchase mobile homes, persons who require hospitalization or live in nursing homes, victims of sexual assault, the critically injured or victims of other life-threatening conditions, parents of Sudden Infant Death Syndrome (S.I.D.S.) victims, high-risk pregnant women and newborns, moth-

ers, infants and children with serious nutritional deficiencies, school children with vision and/or hearing defects, migrant farm workers and many others.

The Illinois Department of Public Health, one of the most diversified of state agencies, is not perfect. Few human institutions are. Undoubtedly, during its second century, the Department will experience frustration and disappointment. It will, however, hold firm to its resolution to meet statewide public health problems with statewide public health responses.

The Illinois Department of Public Health, born in desperation, will meet the future as it has the past. It will maintain dedication to the principles of not just prolonging life, but making it better! ◀

Acknowledgements

I wish to acknowledge the contributions made to this article by the late Isaac D. Rawlings, M.S., M.D., and the late Baxter K. Richardson, A.B.

Much of the material in this article was taken directly from Dr. Rawlings' *Rise and Fall of Disease in Illinois*, a history of the state health department written in 1927 to commemorate the Department's 50th anniversary.

B. K. Richardson's *History of the Illinois Department of Public Health, 1927-1962* was the primary source for sections of this article dealing with those years.

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The First Annual Report of the State Board of Health, July 1877-December 1878.
Department of Health, City of Chicago, Report for 1911-1918.

EKG

(Continued from page 24)

Answers: 1. B, C, D 2. E

The ECG shows tall R waves with a normal QRS duration in leads V_1 through V_4 compatible with severe right ventricular hypertrophy. There is right axis deviation of approximately $+120^\circ$ and left atrial enlargement. The ECG reflects the severe pulmonary hypertension present in this patient and was associated with a slight elevation of pulmonary vascular resistance.

The left atrial enlargement is unusual and is probably related to her congestive heart failure. Heart failure is unusual in atrial septal defect and when seen it is associated with severe pulmonary hypertension. In summary, this ECG is of the type seen in chronic pressure overload rather than volume overload of the right ventricle. Increasing the pulmonary blood flow with a left to right shunt usually causes only modest increases in the pulmonary artery pressure, if any. Significant increases in pulmonary artery pressure are the result of pulmonary vascular changes, and thus increased resistance. Pulmonary hypertension increases the risk of surgical repair of the defect. Our patient did undergo closure of the atrial septal defect and did well. For more information on this area see "Natural History and Prognosis of Atrial Septal Defect" *Circulation* 37:805, 1968.

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SPECIALTY REVIEW MEDICAL ONCOLOGY, September 12
SPECIALTY REVIEW GASTROENTEROLOGY, September 12
STATE & NAT'L. BD. REV., BASIC, September 25,
CLINICAL, Oct. 3
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EKG FOR ANESTHESIOLOGISTS, One Week, October 3
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Doctor's News

PHYSICIANS IN THE NEWS—**Doctor John J. Ring, Jr.**, Mundelein, was appointed First District Trustee at the June 4 meeting of the Board of Trustees. Doctor Ring's appointment, effective until the 1978 annual meeting, fulfills the vacancy left after the resignation of Joseph L. Bordenave, M.D., which the Board accepted "with regrets" at that meeting.

Named as directors of the Illinois Foundation for Medical Care under recently adopted new bylaws were: **Drs. Joseph Sherrick**, Northbrook, president; **Robert P. Johnson**, Springfield, vice president; **James Laidlaw**, Champaign, secretary-treasurer; **Audley Connor, Jr.**, Chicago; **Miller Henderson**, Rockford; and **Lawrence Hirsch**, Chicago.

The Illinois Academy of Family Physicians selected new officers at its annual meeting in June. **Dr. Loren Boon**, Danvers, will serve as president of the Academy and **Dr. Delburt Nelson**, Chicago, was elected president-elect. **Eugene Vickery, M.D.**, Lena, chairman of the ISMS Medical-Legal Council, is the new vice president of the Academy and **Dr. Carl Neuhoﬀ**, Peoria, chairman of the board. **Mack W. Hollowell**, Charleston, chairman of the ISMS Council on Public Relations and Membership Services, was chosen as a member of the board of directors, as were **Drs. Calvin Fischer**, and **John E. Meyenberg**, both of Chicago.

The Illinois Society of Anesthesiologists has announced its newly-elected officers. Chicago physicians **Edward A. Brunner** and **M. Ramiz Salem** were elected to the posts of president and president-elect. **Anthony D. Ivanovich, M.D.**, Glenview will serve as vice president. **Ronald F. Albrecht, M.D.**, Evanston and **Stephen E. Copp, M.D.**, Joliet, were re-elected to their posts as secretary and treasurer. **Doctor Henri S. Havdala**, Lincolnwood, will be 14th District Director for the American Society of Anesthesiologists.

Two Illinois physicians were elected to posts with the American Spinal Injury Association at their annual meeting in April. **Paul R. Meyer, Jr.**, Chicago, was elected president of the association and **E. Shannon Stauffer**, Springfield, was chosen for the post of vice president. . . . **George A. Sisson, M.D.**, Chicago, was named president-elect of the American Academy of Facial Plastic and Reconstructive Surgery at their recent meeting. . . . **Doctor Morris T. Friedell**, Chicago, president-elect of the Chicago Medical Society and president of Jackson Park Hospital and Medical Center, was recently elected chairman of the board for the Hektoen Institute for Medical Research. Doctor Friedell succeeds the late Doctor Morris Fishbein in that post.

A new medical staff has been elected at Rush-Presbyterian-St. Luke's Medical Center in Chicago. **Milton Weinberg, Jr.**, Evanston, senior attending staff in cardiovascular surgery, was elected president and **Joseph J. Muenster**, Chicago, named president-elect. **Ronald L. Dewald**, secretary and **Andrew Thomson**, Treasurer, complete the list of new officers.

Daniel J. Pachman, M.D., Chicago, recently received the Archibald L. Hoynes award of the Chicago Pediatric Society for outstanding contributions in his field. Doctor Pachman is chairman of the Illinois Pediatric Coordinating Council and a professor of pediatrics at the University of Illinois.

LEUKEMIA GRANT ANNOUNCED—The Leukemia Society of America, Inc., has announced that post-doctoral career researchers will be eligible for special grants for study in the leukemia field and allied disorders of the blood-forming organs. The grants include a five-year scholarship totalling \$10,000, two year special fellowships and also fellowships at \$25,000 and \$31,000. Interested physicians should contact Dr. Rose Ruth Ellison, Vice President for Medical and Scientific Affairs, Leukemia Society of America, Inc., 211 E. 43 Street, NY, NY 10017.

GLAUCOMA WARNING—The International Glaucoma Congress has asked that physicians educate their patients in the early detection of glaucoma, which has been called the third leading cause of blindness in the United States. The Congress estimated that more than eight million Americans have the disease—and nearly half of those persons are unaware of its presence. Because no warning symptoms commonly assert themselves, early detection—and prevention—are often impossible. Physicians are urged to instruct their patients in the importance of glaucoma testing on a regular basis.

COMATOSE STUDY—A neurologist at the University of Chicago recently reported findings on a new test developed to predict the survival possibilities for comatose patients who have suffered severe head injuries. Based on nerve signals from the brain's "sensory cortex," the test utilizes electrodes connected to specific cortex areas and placed on the patient's scalp. According to Jack de le Torre, M.D., who conducted the study, it is hoped—though not proven—that the technique will provide "an extremely reliable index for the outcome of such (comatose) patients."

SICKLE CELL GRANT—The National Institute of Health has granted a five-year, \$4 million grant to expand the University of Illinois Sickle Cell Center. The Center, first established as part of the Abraham Lincoln School of Medicine in 1972, is the first of its kind in Illinois, and among only 10 such programs nationally. It is used by the Chicago and Illinois health departments for identification of abnormal hemoglobin, and includes the only sickle cell eye clinic in the world.

The Center provides inpatient and outpatient services as well as training and research for health care professionals. A comprehensive community education program is also directed under the aegis of the Center.

ABOUT THAT HEALTH CARE COST CRISIS—The AMA has gathered statistical data from the 1976 Consumer Price Index (CPI) to form a comparison of rising health costs versus general inflationary trends. The CPI, which is based on 1967 prices, reported that medical care had risen by 184.7 points.

Interestingly, insurance and finance charges stood at 196.6, postage at 222.3, and diapers 190.2. The 1976 CPI for blue jeans was 190.0, coffee 243.6, sugar 201.3, heating and cooking gas 200.9, and toilet paper 234.4.

Per capita income, of course, has also risen, standing at 202.0 for 1976, and the AMA estimated that the maximum social security tax on employees, if recorded, would have been reported at 308.2.



CREDIBILITY

Credibility is a characteristic vigorously sought by individuals and organizations. While it frequently is attained by individuals, credibility remains elusive for most organizations composed of those same people. For example:

- Used car salesman can't be trusted . . . but the one I deal with is reputable.
- Auto mechanics are "rip-off artists" . . . but my mechanic has provided satisfactory service for many years.
- Lawyers are shysters . . . but my attorney always represents me fairly and gives me good advice.
- Physicians are arrogant and greedy . . . but my doctor is the greatest.

Those examples summarize our status in society. Organized medicine is viewed with a critical eye. But recent polls indicate that individual physicians have tremendous credibility with the general public. That's a valuable asset. Unfortunately, the vast majority of physicians seem reluctant to use their credibility to fight government's attempted take-over of the profession.

Patients are potential voters who can have a significant impact on the legislative process. More importantly, they are our strongest allies. Take the time to tell patients about the deleterious effects of government control on their health care. Urge them to voice their concerns to legislators.

If each physician did his part, the profession would have more clout than bar associations, Common Cause and even the unions.

Put your credibility to work. Time is running out.

A handwritten signature in cursive script that reads "George T. Wilkins, Jr.".

George T. Wilkins, Jr., M.D.

Annual Educational Symposium Scheduled

The Professional Medical Assistant: A Real Treasure

The American Association of Medical Assistants, Illinois Society, will hold an all-day educational program on Sunday, September 18, 1977, at the Elmhurst Inn in Elmhurst, Illinois. The symposium represents an annual culmination of daily efforts to define and disseminate an understanding of the nature and function of the medical assistant. The lectures, coordinated by the DuPage County chapter, are designed to be of interest to medical personnel in all capacities and non-members as well as members are urged to attend.

Following registration at 8:30 a.m., the morning lectures will be initiated by Richard F. Gallagher, M.D., an associate clinical professor at Loyola University and staff physician at both Good Samaritan and Hinsdale Hospitals, who will relate specific personality traits essential to the professional medical assistant. Dr. Gallagher will consider predisposing skills and attitudes common to those who succeed in achieving optimum efficiency.

Ronald H. Stefani, M.D., F.A.C.S., physician-advisor to the DuPage County Chapter, AAMA, will describe the expectations physicians hold for their medical assistants. Implementing the perspective of an individual physician-employer, Doctor Stefani will define duties, responsibilities and possible areas of expansion in the office setting.

David Bauer, III, administrator for the Glen Ellyn Clinic, Glen Ellyn, will confront the realm of office management technique. Efficient office management plays a crucial role in today's office practice, and the lecture will highlight areas of concern and methods to streamline patient flow.

A positive self image on both personal and professional levels, as well as a cooperative spirit and desire to learn will be among the qualities delineated by Mrs. Sylva Temple, CMA, Second Vice President, AAMA, Illinois Society, in her discussion of the certification process. Mrs. Temple will emphasize the importance of continuing education for the practicing medical assistant and the personal satisfaction of achieving certification.

Following luncheon, the clinical portion of the symposium will be initiated by Edwin Dolan, M.D., chief radiologist of the CAT Scan Unit for Mercy Center in Aurora, Illinois, who will explain the nature of the CAT scan, its functions and its benefits. Concluding the clinical presentation, Mr. Jerry Davis, sales representative for Medtronics, Inc., will demonstrate "Tele-trace," a new transmitter and receiver for telephonic electrocardiograms.

A representative of the DuPage County Medical Society will conclude the symposium with an update on activities of the Illinois Medical Political Action Committee (IMPAC).

Out-of-town participants will be welcomed by Mrs. Sherie M. Everhart, chairman, and members of the DuPage County Chapter, AAMA, on Saturday evening at the Elmhurst Inn, 933 S. Riverside Drive, Elmhurst, 60126. (Members are advised to contact the hotel in advance for overnight accommodations.)

Please complete the coupon below and mail to Sherie M. Everhart, Chairman, 344 Normandy Drive, Addison, Illinois 60101; (312) 834-2120.

Registration Fee: \$8.00. Please make checks payable to: AAMA, DuPage Chapter, Annual Educational Symposium.

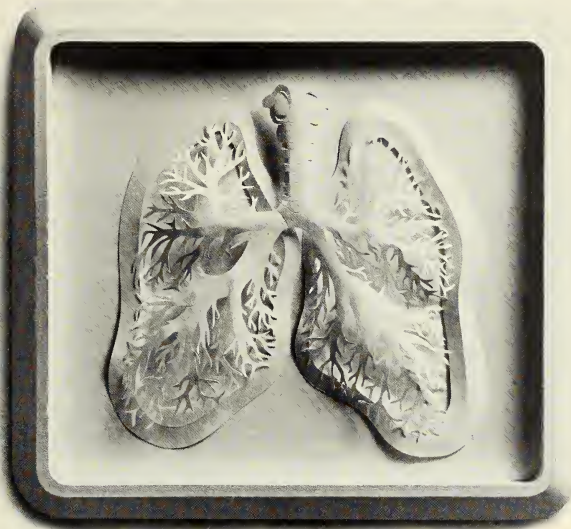
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Letters to the Editor

John M. Beal, M.D., Editor
Surgical Grand Rounds

Dear Doctor Beal:

The November issue of *IMJ* includes Dr. Boris Reisberg's article entitled "Case Report: Summary of Surgical Infections—1975" and represents part of the Surgical Grand Rounds of July 6, 1976 at the Passavant Pavilion of Northwestern Memorial Hospital. Page 543 of the report merits comment.

According to Dr. Reisberg: "Handwashing using . . . or Betadine is not very effective in reducing the number of gram-negative organisms on our hands." Unfortunately, data supporting this conclusion are lacking.

We call attention to the well-known broad range of microbicidal activity of Betadine (povidone-iodine) products according to *in vitro* experiments against gram-positive and gram-negative bacteria, fungi, viruses and protozoa.

The independent findings of Dr. Hiram Polk¹ and Dr. Peter Dineen² illustrate the utility of handwashing with Betadine Surgical Scrub® for removal of deposited *E. coli* and *Ent. Aerogenes*. Moreover, Dr. Dineen demonstrated protection

against a subsequent reinoculation of *E. coli*.

According to Knittle *et al.*,³ handwashing with Betadine Surgical Scrub® by 9 intensive care nursery personnel led to a marked reduction in gram-negative bacteria, i.e., only 3 of 39 cultures, obtained at random, showed a total count of 1,000 or more, 19 others failed to reveal any gram-negative bacteria, and the remaining 17 had counts of less than 1,000.

Sincerely yours,

Kenneth G. Rothwell, M.D.

Director

Eugene A. Conrad, Ph.D.

Associate Director

Medical Department

The Purdue Frederick Company
Norwalk, Conn.

References

1. Polk, H.: "Comparative Study of Agents for Degerming Hands Heavily Contaminated with Pathogenic Bacteria," *Proceedings of Therapeutic Advances and New Clinical Implications: Medical and Surgical Antisepsis with Betadine Microbicides*. 91-94, 1972.
2. Dineen, P.: *Ibid.* p. 107-109 (Discussion).
3. Knittle, M. A.; *et al.*, "Role of Hand Contamination of Personnel in the Epidemiology of Gram-Negative Nosocomial Infections," *J. Ped.* 86:433-437, 1975.

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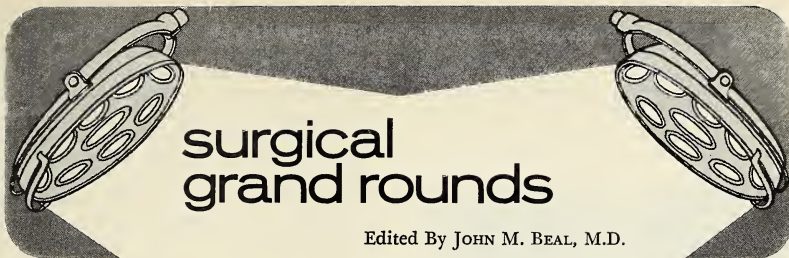
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Edited By JOHN M. BEAL, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of February 15, 1977.

CASE REPORT:

Carcinoma of the Duodenum

Dr. Michael Verta: A 59-year-old man noticed dark, amber-colored urine and light stools three weeks before admission. He stated that he had also lost his taste for beer at the same time. A 25 pound weight loss had occurred during the preceding month due to a loss of appetite, although he denied nausea, vomiting, or abdominal pain. His past history was essentially unremarkable.

Physical examination revealed a jaundiced, chronically ill man with normal temperature and vital signs. Examination of the head, neck, chest, and heart was within normal limits. Examination of the abdomen revealed a palpable liver edge, 2cm below the right costal margin, which was smooth, round, and slightly tender. Other masses or organs were not felt. Rectal

examination was unremarkable and the stool did not contain occult blood.

Admission laboratory studies include a normal hemogram, an alkaline phosphatase level of 470 mu/ml (normal 30-85 mu/ml) and a bilirubin of 8.9 mg%. Electrocardiogram showed a right bundle branch block, and the chest X-ray was normal. Antibody and antigen titers for hepatitis B and the VDRL were negative.

A clinical impression of extrahepatic biliary obstruction was made. A B-mode ultrasound study of the abdomen demonstrated a dilated biliary tree. However, the pancreas was poorly visualized. Proctoscopy and lower gastrointestinal exams were normal. An upper gastrointestinal series and transhepatic cholangiography were performed.

Dr. Ann Woodruff: The first film from the upper gastrointestinal examination primarily showed the three sign of Frostbera. The mid portion of the "three" is felt to be secondary to some tethering of the duodenum in the region of the papilla, while the surrounding

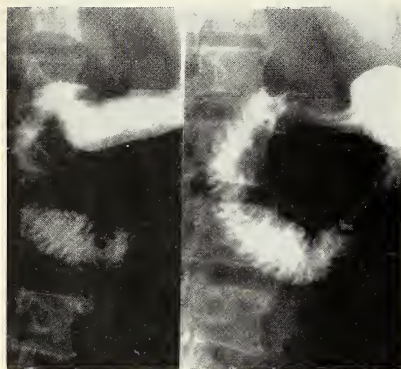


Figure 1

Films from the upper gastrointestinal series illustrate the "figure of 3" sign which is associated with ampullary neoplasia.

edges are felt to be either edema or an area of muscle spasm in the duodenal wall, depending on the etiology for the reverse three sign. (Fig. 1)

We discovered that the area of the papilla was not smooth, but no other findings were noted. There was no evidence of extrinsic pressure as from a mass, and there was an absence of mucosal effacement or spiculation, both of which are found with peripancreatic or pancreatic disease. The primary finding is related to the area of the papilla and is in the form of irregular nodularity of the papilla itself with loss of the straight segment and longitudinal folds. Both of these are landmarks used by radiologists for definition of the papilla and, therefore, of the entrance to the pancreatic and common ducts.

A percutaneous transhepatic cholangiogram was performed to visualize the distal segment of the common duct. A segment which measures a little over 3cm is irregular and quite narrowed. (Fig. 2) This accounts for the dilated intrahepatic biliary ducts by ultrasound. The

specific diagnosis cannot be made radiographically, but the findings are consistent with a variety of disorders in the vicinity of the papilla of Vater, including pancreatic carcinoma, chronic pancreatitis, and papillary carcinoma of the duodenum.

Dr. Michael Verta: A diagnosis of malignant biliary tract obstruction was made and exploratory laparotomy was performed. A tumor was found which originated from the duodenal wall and involved the ampulla of Vater. The tumor invaded the head of the pancreas. Frozen section from a biopsy of the duodenal tumor was interpreted as adenocarcinoma and a pancreatoduodenectomy with total excision of the pancreas was accomplished. His postoperative course was uneventful and he was discharged on the

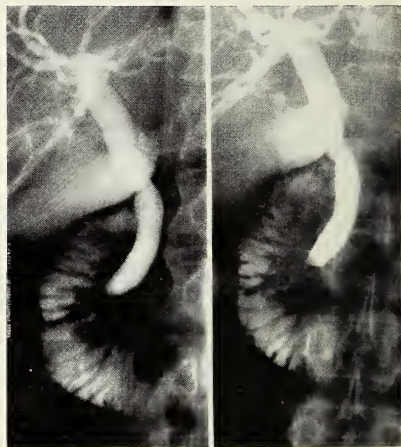


Figure 2

Percutaneous transhepatic cholangiogram demonstrates narrowing of the terminal portion of the common duct with proximal dilatation.

21st postoperative day with his diabetes well controlled.

Specimen Described

Dr. Hector Battifora: The specimen consisted of gallbladder, part of the stomach, the entire pancreas, and part of the duodenum.

A whole mount was made of part of the

head of the pancreas, including part of the duodenum. (Fig. 3) There was a very clear cut area of ulceration involving the region of the ampulla. Normal duodenal mucosa and some abnormal mucosa were present at the edge of the ulcer. In addition, the tumor was invading and destroying the wall of the small bowel. The wall of the common duct appeared narrowed and invaded by some tumor. The head of the pancreas did not seem to contain any tumor in this section, as was the case for

History and Nature

Dr. Michael Verta: Carcinoma of the duodenum is uncommon. The first pathologic description was that of Hamburger in 1746, but clinical recognition by Matier and Hartman did not occur until 186 years later. Duodenal carcinoma accounts for only 0.03% of all human cancers and only 0.3% of all gastrointestinal malignancies. However, it accounts for almost half of all small bowel cancers. The peak incidence of this neoplasm occurs in the fifth and sixth decade, although isolated cases have been reported as early as the second decade and there is even one case reported in a child three years of age. Men and women are affected with equal frequency. Nearly half of duodenal carcinomas are found in the second portion of the duodenum and, thus, are perampullary.

Duodenal carcinoma is locally invasive and metastasizes to the liver late in its course. Distant metastases are usually rare. Adenocarcinoma, as in this case, is the most common cell type, accounting for about 87% of the cases, while carcinoids are second in frequency. Three morphologic types have been described. The type I tumor is a polypoid mass which usually presents with duodenal obstruction and seems to carry the best prognosis. Type II tumors are usually perampullary in location and commonly present with jaundice and occult blood in the stool. These are the most aggressive tumors and carry the worst prognosis. Type III is a combination of the other two types, but seems to behave biologically like type II tumors. The most common presenting symptoms are weight loss, anorexia, and occult blood in the stool. Jaundice is common in the perampullary tumors, but occurs in only about one-third of the patients with duodenal carcinoma. Hematemesis and melena are unusual. The diagnosis of duodenal carcinoma is seldom made preoperatively. It is quite difficult to do so. Physical signs usually are not helpful. Duodenal cytology has been used with little success. Upper gastrointestinal radiologic study, with or without hypotonic duodenography, remains the most reliable non-invasive test although an accuracy as low as 65% has been reported. The radiologic signs of duodenal carcinoma are those associated with perampullary tumors and may range from subtle mucosal alterations to a reverse 3 sign, which was present in this patient. A napkin-ring deformity is radiologically typical of a primary duodenal tumor. When obstructive jaundice is present, transhepatic cholangiography

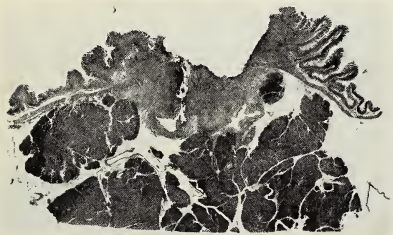


Figure 3

Whole mount of the ampulla of Vater shows ulceration. Tumor was found invading the base of the ulcer.

several other sections. The tumor did invade very close to but not into the pancreas.

There was an area of transition from the normal mucosa to one showing a villous hyperplasia leading into an area of invasive cancer under the mucosa of the intestine. The finding of villous changes is strongly supportive of primary origin in the duodenum and was very helpful in guiding us at the time of the frozen section. This aided in distinguishing a tumor arising in the duodenum rather than in the pancreas. The histologic pattern of invasive duodenal cancer cannot be distinguished from pancreatic cancer. In other words, to make a diagnosis of primary carcinoma of the duodenum, it helps to demonstrate the tumor arising in the mucosa and even better if one can see premalignant changes in the mucosa next to the tumor. Several lymph nodes, quite large, were found but were, fortunately, enlarged due to sinus histiocytosis. This hyperplasia of the sinuses is most likely secondary to the ulceration, rather than to immune response to the tumor, but the latter possibility cannot be excluded.

provides helpful information. However, the single most reliable examination for duodenal carcinoma is fiberoptic endoscopy with biopsy and retrograde cholangiopancreatography.

Treatment Approach

The treatment of carcinoma of the duodenum is surgical. Local excision of the tumor is inadequate because it violates the basic principles of good cancer surgery and has not resulted in a single cure. Palliative bypass operations should be reserved for those patients found to be unresectable at the time of laparotomy. Because the likelihood of duodenal obstruction is great in these patients, gastrojejunostomy should be routinely employed. The only curative treatment for this disease is pancreatoduodenectomy. There is a high rate of resectability, ranging from 38 to 50% of all patients explored. The morbidity and mortality in larger series varies between 12 and 20% and is sufficiently low that every attempt should be made to resect the tumor.

The results of radical operation are reasonably good with an average five-year survival of over 30%, in comparison to approximately 12% for carcinoma of the pancreas.

Discussion

Carcinoma of the duodenum is uncommon, but is the most common site for small bowel carcinoma. Nearly half of these tumors occur near the ampulla and produce weight loss, anorexia, and obstructive jaundice. The diagnosis is made best by a combination of radiographic and endoscopic techniques. Radical resection produces a reasonable five-year survival rate and should be considered to be the procedure of choice.

Dr. Stuart Poticha: Carcinoma of the duodenum is so rare that at one time, it was thought that the duodenum had some special protection against carcinoma. In the early 1950's, a serum was made from hog duodenum which was used to treat cancer. It was unsuccessful. Despite an extensive preoperative work-up, gastroscopy, although considered, was not performed. In retrospect, it would have been very helpful because the duodenal carcinoma was visible and could have been biopsied at the time of gastroscopy. As it was, at exploration, we could not tell whether it was duodenal or pancreatic carcinoma. The tumor was small; I was reluctant to embark on a resection in this patient without a posi-

tive tissue diagnosis. We tried to do a needle biopsy through the wall of the duodenum into the pancreas but were unsuccessful. Finally, we opened the duodenum on the antimesenteric surface across from the tumor, saw the ulcer, and biopsied it. I think this is not ideal and could have been avoided by performing endoscopy prior to operation.

We were not able to tell on the frozen section whether this tumor arose in the pancreas or the duodenum. This is an important point because I chose to do a total pancreatectomy, rather than simply removing the head of the pancreas with the duodenum. There were two reasons for this. First, the incidence of postoperative complications are much less when a total pancreatectomy is performed. Secondly, carcinoma of the pancreas may very well be a multifocal disease and frequently when the disease recurs, it recurs in the stump of the pancreas that is left behind. I have seen one instance of such recurrence in a patient who had carcinoma of the pancreas which ulcerated into the duodenum. He lived for three years and when the disease recurred, it recurred in the pancreatic stump. As a result, I have chosen to do total pancreatectomy in patients with resectable carcinoma of the pancreas. In this patient, I might have been more reluctant to perform a total pancreatectomy, had we known beforehand that it was carcinoma of the duodenum.

Dr. John Beal: Do you think you could have told endoscopically that this was carcinoma of the duodenum?

Dr. Stuart Poticha: No. I don't think we could have told endoscopically; however, we might have been able to tell pathologically on a permanent section. At operation, we could not tell on the basis of frozen section. Even if we were unable to determine if the tumor arose in the pancreas or duodenum, a permanent section would have obviated the need for opening the duodenum to obtain a biopsy. We would have known that we were dealing with a malignant tumor and I think that's worth knowing. ◀

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Security of Hospital Medical Records

The ISMS Board of Trustees has approved a series of guidelines designed to safeguard the security of hospital medical records. The cynosures were proposed by the ISMS Task Force on Professional Liability. They culminate a lengthy analysis of procedures for handling confidential information at several Illinois institutions.

Although these pertain primarily to administrative personnel, physicians who serve as hospital staff are encouraged to maintain an awareness of their content and recommend appropriate application.

1. All employees of the Medical Records Department should be carefully screened at the point of hiring and the Director of the Department, or his or her designee, should personally make certain that each employee is fully qualified and is aware of the "special trust" with respect to the confidentiality of medical records bestowed upon them in their employment;

2. If the Department utilizes any outside contractor for services (housekeeping firm, secretarial pool, etc.) the Director must take personal responsibility for making certain that no unreasonable risks of "security leaks" are the result of such contract services (such as the use of codes in lieu of names);

3. The Director of the Department must ensure that a "failsafe" system of controlled access to the records room is in force. Either through seven-day a week, twenty-four-hour coverage, or by other means, any access by employees of other hospital departments or the Administration or the Medical Staff must be monitored and accounted for;

4. Persons not associated with the hospital should not be allowed access to the Records Room. If adequate space is available, a separate room should be provided for attorneys, law enforcement officials and others who have a legal right to review and copy the records (upon proper release from the patient);

5. In keeping with the recently amended Illinois law (H.B. 3957) the hospital must cooperate with attorneys and physicians representing patients, who wish access to their records. However, the Medical Records Department does *not* have to waive all reasonable procedures and policies it applies to others in order to be in compliance with the law. The request for access to the records should be *presented in writing*

addressed to the Hospital Administrator (who should set up a reliable system for referring these requests promptly to the Director of Medical Records, reasonably well in advance of the time the records are required.) The hospital should require that all attorneys or physicians seeking records provide the hospital with a written authorization from the patient. The hospital should only accept the *original* authorization form and should verify the signature against the Medical Record (in order to guarantee that a valid signature can be found in each patient record, the hospital might consider obtaining a "signature card" from each patient at the time of admission and making that card an official and permanent part of the record);

6. A current log should be maintained by the Medical Records Department of each person requesting access to a patient's record. The log should indicate the name, address and capacity of the person requesting the record; the name of the patient; the date and the reason for the request and such other information as the hospital may deem essential. The log and the patient's release forms should be retained for at least two years (two years after the date of majority for a minor). It should include hospital employees of other departments who seek access to patient records as well as outsiders;

7. There should be a written policy developed (with input from the Medical Staff) regarding security measures to be observed in the management of the Medical Records Department. This policy should define the purposes for which hospital personnel may obtain medical records and the methods of accountability to be utilized (the log, etc.) so that employees will be forewarned of and deterred from violations of these security measures;

8. Whenever a request is made for a patient's record, and after the patient's authorization has been verified, the Department should notify the patient's attending physician (that is, the physician or physicians who held the major and primary responsibility for the care of the patient for that period of hospitalization covered by the records in question) that the record has been examined and/or copied;

9. In the event the hospital or a member of its medical staff is subpoenaed or is named a party (defendant or respondent) in a lawsuit, the Medical Records Department should mark the patient's records involved in such procedures or litigation for "special handling" and thereafter exercise extraordinary precautions against unauthorized access to these records;

10. Although wide-based immunity exists for the hospital and individuals (physicians and others) for peer review and quality assurance activities, the Medical Records Department must outline specific procedures for the maintenance of confidentiality of names of patients and doctors and details of events related to patient care, which are subject to such monitoring and evaluation.

tion. It is conceivable that in the absence of reasonable safeguards, followed by a serious breach of confidentiality, the hospital's immunity could be challenged under a charge of "wilful and careless" behavior (akin to malice, in the view of some courts), with respect to the dissemination of confidential information;

11. Educational programs should be developed to help doctors, nurses and other hospital personnel who "chart," to be careful and accurate and to avoid unnecessary and often incriminating entries into patients' records, and procedures should be adopted to ensure security for medical records while retained at the nursing station.

12. The hospital should adopt, with advice of legal counsel, proper procedures for reporting and filing reports of untoward incidents (which may or may not give rise to litigation). If properly handled these documents, which are necessary for insurance risk management and educational purposes, can be categorized as an "attorney's work product" and perhaps thereby become immune from subpoena (for discovery purposes) in connection with litigation against the hospital or its physician.

MANUSCRIPT INFORMATION

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed.

Manuscripts should be typed, double spaced, and submitted in duplicate, one original and one carbon. An article should not exceed **12 to 16 manuscript pages**, (including illustrations) and should be briefer if possible. Please enclose personal glossy photos of author or authors. Snapshots are not suitable for reproduction.

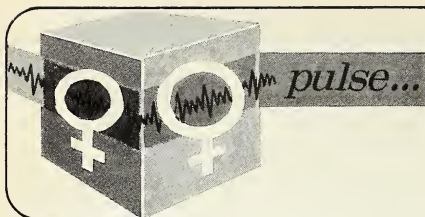
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The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively and indicate their place in the text. Number, indicate the top and place the author's name on the back of each illustration.

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pulse... of the doctor's wife

MRS. EUGENE VICKERY, Editor

KEY LINES:

Kaleidoscope

By BETTY SZEWCZYK, PRESIDENT, ISMSA

The beautiful, constantly changing symmetries of a kaleidoscope require close examination. In the past few weeks, I had the opportunity to take a tall view of auxiliaries in action, and I was struck with the myriad of programs and projects being accomplished by medical auxiliary. A great deal of time is required to enjoy the designs and colors of various shapes and hues.

The overview began in St. Louis at the Missouri Medical Auxiliary Convention. The group had certainly "charted new courses" with a very active auxiliary year. I was most impressed with a program called "Medicine and Marriage." A three hour seminar, co-sponsored by the Auxiliary, the MSMA and Missouri Psychiatric Association, was conducted by Gordon H. Deckert, M.D., who enlightened, enlivened and entertained with enviable knowledge, talent and finesse. He began by telling us that "feelings begin a marriage, process makes it work." One of the things Dr. Deckert recommended was a "daily psychological inventory." We came to recognize different types of persons and how their attitudes affected their marriages—nurturing parent, punitive parent, computer, scared kid, cheated kid, sad kid—they were all there, married, and struggling for a relationship.

Indiana answered our lament: "someday I'm going to get organized" with Frank M. Sterner, Ph.D., who spoke about "Managing Your Time and Your Life." He told us that we must manage our time better and work for efficiency, effectiveness and long term planning. Somehow or other I kept thinking, "yes, but if he had my problems. . . ."

Another look into the auxiliary kaleidoscope occurred at our own Illinois annual meeting in Chicago. Dr. James W. West, chairman of the Panel for the Impaired Physician, allowed us a look into the work of this important and timely group. The Panel consists of physicians helping physicians with illnesses involving alcoholism and drugs. They invite any physician or a member of his immediate family who wishes help or guidance to call a member of the Panel. A call for help will provide information, consultation or a personal visit by a physician who is qualified to help, and who is able to offer counsel and referral to a treatment program if indicated. All contacts are held in the strictest confidence. A list of Panel members can be obtained from the ISMS office.

Iowa concentrated on "The Art of Communication" during the past year. TV personality Mary Brubaker was a living image of communication, the luncheon displays were professional, and every program was artfully handled. A detailed description of Iowa HMOs (Home Services Agency in Iowa) was especially interesting. For those of us who find legislative talks vague and elusive, this step-by-step description was a delight.

A film called "Heart Attack!" was also presented to relay, in a most breathtaking and descriptive fashion, the city of Seattle's approach to the "Sudden Death" problem. We hope to obtain this film in order that Illinois auxiliaries might help fellow citizens to recognize the importance of Cardiopulmonary Resuscitation (CPR). Thousands of lives might be saved

through a program educating the public to recognize danger signs and give immediate life saving assistance. Cardio—heart; pulmonary—lung; resuscitation—revival. An immediate response, with this simple technique, can maintain life until help arrives. Any teenager or adult can learn to perform CPR.

As I glanced through the program of the Michigan Medical Auxiliary Convention, my eyes halted at "Blood Lottery Drawing." I didn't want my imagination to run wild on that one, so I did a quick investigation. In its "awareness" drive this year, Michigan stressed the importance of blood donations. To be eligible for the drawing, an auxilian had to have given blood at least once during the past year: "A gift of blood is a gift of life." The Director of the Michigan Red Cross Blood Center added to the interest with his lecture: "Blood—What Is It and For What Is It Used?"

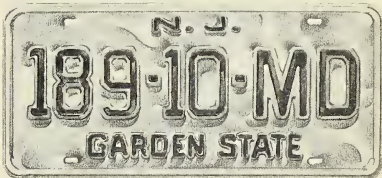
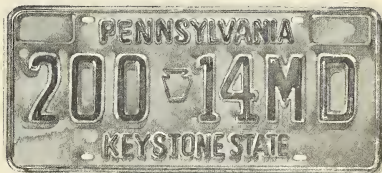
Ohio Auxiliary joined the OSMS at a general session where the discussion was "Public Attitudes Toward Health Care and Malpractice Solu-

tions." A survey was taken on consumer opinions about health care. Public confidence in key institutions has eroded for many reasons, but medicine has fared rather well. Negative attitudes toward doctors came from the young, particularly those under twenty-five, but college educated persons were more favorable. In conclusion, the survey found that the important tool is *communication* with and *listening* to the patient.

TV—the great American passive sport—was spotlighted in Missouri, Indiana, Illinois, Iowa, Michigan and Ohio. All auxiliaries are anxious to join the AMA and the PTA in their campaigns against TV violence. By the time a child is age 19, he has watched over 18,000 hours of TV and has seen 250,000 commercials. We must design a process to make TV a learning experience. Become selective—don't make a friend of the TV.

My look into the kaleidoscope of auxiliary in action had to be a long one. There was too much beauty and interest for a quick glance.

You and Auxiliary can make a difference.



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Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

ARCOLA: F.P. or G.P. needed to join only physician in true rural community (2,300 population). Must be willing to do O.B. Ultimate plans for new 3-man clinic. Close to beautiful county hospital less than 10 years old. Robert N. Arrol, M.D., 126 S. Locust, Arcola, Illinois 61910. (217) 268-4444 or (217) 268-4404. (10)

BEMENT: Population around 1800. Take over established practice of 30 years. Complete office facilities. Financial assistance available. New nursing home. New hospital and nursing home 7 miles. Located 25 miles from Decatur, 30 miles from Champaign hospitals. Choice of newly decorated home city or country. Contact: Mayor J. E. Hargrave, 633 E. Bodman, Bement, 217-678-8186 or Dr. Wm. Scott, 107 E. Bodman, Bement, 217-678-5151. (9)

CANTON: Clinic established in 1937 serving the Spoon River Valley area. This multi-specialty clinic is located in a clinic building constructed in 1969, located two blocks from 250-bed hospital. Twelve physician group. 30 miles from Peoria School of Medicine. Contact: Harlan Crouch, 175 S. Main, Canton, 61520. 309-647-0201. (8)

CHICAGO: Progressive Community Hospital with active Emergency Department seeking an Orthopedic Surgeon. Good facilities available. Financial package attractive. Contact: Joel V. Bailey, 326 West 64th Street, Chicago 60621—312-962-4100. (8)

CHICAGO (desirable suburb): Older general practitioner has excellent office facilities to share with younger G.P. Objective: need help with practice. Younger man may have guarantee to take over practice in near future. Hospital staff appointment available. All replies confidential. Box MK, Physician Recruitment Program, ISMS. (9)

CHICAGO: Take over large general practice. No investment required. Modern fully equipped and staffed facility. Salary and profit sharing. Contact: Jack Pardee, Suite 300, 2400 E. Devon, Des Plaines 60018. 312-298-3500. (9)

CHICAGO: Medical Center with complete facilities needs physician full time for welfare practice. Part

time hours are also available. Above average earnings obtainable. Contact: Mohawk Medical Center, 832 West Madison Street, Chicago, Illinois 60607. (312) 421-2199. (9)

CHICAGO: Beautifully furnished and equipped medical suite in brand new medical clinic, with lab and ECG, available now in busy commercial area for GP, Ob-Gyn or Ped. 1620 W. Belmont, Chicago 60657. 935-8900. Mr. Cabreira. (10)

FAIRBURY: population 3,500; fully accredited modern hospital in progressive rural community located 100 miles southwest of Chicago servicing 15,000. Housing, office, and financial assistance available. Only five general practitioners and one board eligible surgeon serving area. Contact Donald Patterson, Administrator; Fairbury Hospital, 519 South Fifth Street, Fairbury, 61739, (815) 692-2346. (8)

GENESEO: Physicians wanted for Family Practice, OB-Gyn, Pediatrics, Internal Medicine, General and Orthopedic Surgery. Attractive, prosperous, residential community of over 7,000; serving trade area of 35,000 population. Located on Interstate 80, 2½ hours from Chicago; 25 miles east of Quad Cities metropolitan area of 350,000. Ideal, safe, small city living with excellent recreational facilities. New ultra modern hospital with 110 beds. New modern doctor's offices and housing on hospital property immediately available. Attractive financial arrangements include guarantee. Contact Physician Recruitment Committee, 210 W. Elk St., Geneseo, 61254 or phone collect; G. L. Wissink, Administrator (309) 944-6431. (10)

HINSDALE: Seeking physicians for church-related, fee-for-service, family health centers in Chicago western suburbs. Competitive salary, facilities, equipment, malpractice insurance included. Continuing education, patient education, counseling staff, teaching of medical students and residents. Contact Bill Peterson, Pastoral Director, Wholistic Health Center, 137 S. Garfield, Hinsdale, 60521. Phone (312) 986-5252. (9)

KEOKUK, IOWA: Progressive industrial community of 15,000 with 40,000 service area. Opportunities for family practice and internal medicine, solo or group practice. Complete office facilities, financial guarantee and assistance available. Located on Mighty Mississippi. Contact: Dr. Lynn L. Walker, Keokuk Area

Hospital, P.O. Box 1500, Keokuk, Iowa 52632. AC 319-524-7150. (9)

LaSALLE-PERU: Board certified or eligible anesthesiologists to head department in North-Central Illinois hospital serving 35,000 area population. Four CRNA's currently on staff. Located two hours from Chicago, this area offers recreational facilities, good schools and housing. Contact W. T. Schweickert, Administrator, 925 West St., Peru, 61354. 815-223-3300. (10)

LIBERTYVILLE: Family practice physician, G.P. or internist to join new outpatient clinic consisting of full auxiliary facilities, special procedure rooms and future outpatient surgical center. Located in a rapidly growing area near lakes, shopping centers, recreation areas and easy access to Chicago theaters, museums and cultural events. For information call 312-362-0020, write Dr. G. Gavary, 611 S. Milwaukee, Libertyville, 60048. (9)

MURPHYSBORO: Board certified or eligible, one pediatrician, one surgeon; to join a solo OBS-GYN in a progressive community hospital. Enjoy golf, deer hunting, fishing, water sports in beautiful pollution free area. Guaranteed income, excellent fringe benefits with progressive increases and partnership in three years. Interested applicants contact: U. Matias, M.D. 618-687-1901 home, 618-687-3351 office. (10)

OREGON: Population 3800. Northern Illinois' most beautiful little town needs physician. On Rock River, two State Parks, 16 local industries. New Doctor with 3-year old practice would welcome associate. Great opportunity. Contact: Jean Davis, Etnyre Terrace, Oregon, 61061. Tel. 815-732-6248. (8)

PEORIA: Emergency Medicine Residency Program seeks faculty for positions beginning immediately and July 1, 1977. 850 bed university affiliated hospital located in Central Illinois. Regional Trauma Center with 45,000 undifferentiated ER patient visits annually. Positions combine academic and clinical responsibilities in developing residency program. Inquiries limited to certified/eligible primary care specialists (Internal Medicine, Pediatrics, Surgery) or graduates of ER residencies. Salary competitive with numerous fringes including malpractice. Send replies to Mr. Ronald Pechan, Assistant Administrator, St. Francis Hospital-Medical Center, 530 N.E. Glen Oak, Peoria, 61637. (309/672-2298). (8)

ROCKFORD: 250-bed hospital-Regional Trauma Center seeks Emergency Room Physician interested in EMS programs. New paramedic program; affiliated with Rockford School of Medicine. New emergency room facilities include x-ray capabilities; state-wide radio network; Poison Control Center; heliport. Second largest city in Illinois, located one hour west of Chicago and close to Wisconsin resort areas. Contact: Bob Flodin, St. Anthony Hospital Medical Center, 5666 East State Street, Rockford, 61101 (815) 226-2010. (10)

SULLIVAN: A new \$1,000,000 medical facility is looking for doctors in a midstate town of 4,000. It offers challenging positions for creative individuals to design and implement patient-care programs. Partnerships with established doctors also available. Three hospitals are within thirty miles. An 11,000 acre recreational lake is nearby. Contact: Bob Lemler, 200 S. Hamilton, Sullivan, 61951. 217-728-4311. (10)

TUSCOLA: Internist needed. Excellent hospital facilities. Located twenty miles from Champaign-Urbana and the University of Illinois campus. Financial assistance, office facilities available. Contact Norm Rentz, 704 N. Main St., Tuscola, 61953. (217) 253-3361. (10)

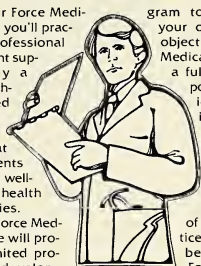
WASHINGTON: Population over 10,000. Physician recently moved to Florida. Three physicians at present. Eleven miles from Peoria's three hospitals and Peoria Medical School. Some financial aid available. Excellent schools, parks, etc. Contact: Dean R. Essig, 135 Washington Square, Washington, 61571. (309) 283-8041. (9)

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Abstracts of Board Actions

(Continued from page 9)

To initiate action on House of Delegates' directives concerning Medicaid problems, ISMS will:

- Emphasize to IDPA the need for prior-to-payment Medicaid review and stress that efforts to recoup funds should be conducted only in cases of fraud and/or abuse.
- Authorize legal counsel and staff to investigate—in conjunction with the Illinois Clinic Managers Association—IDPA's discriminatory reimbursement practices.
- Meet with IDPA Director to select representatives from the ISMS Governmental Health Program Reimbursement Committee and IDPA who will work to: (A) Develop a mechanism and timetable to implement recent ISMS-IDPA agreements and discuss unresolved items involving audit procedures; and (B) Devise a method of responding to directives by the 1977 House of Delegates.

The Board also authorized legal counsel to develop an authorization mechanism for use when physicians request ISMS assistance in resolving Medicaid billing/reimbursement problems. IDPA had requested that ISMS obtain the authorization prior to discussing problems with the Department on behalf of an individual physician.

In response to complaints regarding IDPA's recently-imposed requirement that all prescriptions in Cook County must contain the physician's Drug Enforcement Authority Number, the Society will inform IDPA that:

- ISMS opposes the new regulation
- Implementation violates the intent of IDPA assurances that ISMS would be notified prior to all rule and regulation changes
- ISMS is considering development of legislation amending the Administrative Review Act to require that IDPA provide public notice 60 days prior to any proposed regulation changes.

Administrative Services for Clinic Managers Association

ISMS will provide administrative services for the Illinois Clinic Managers Association (ICMA) on a cost basis, with ICMA reimbursing the Society for staff services and out-of-pocket expenses. ICMA is a state chapter of the Medical Group Management Association. Its 65 members manage clinics staffed by approximately 2,300 Illinois physicians. The Board also agreed to:

- Invite ICMA to appoint non-voting representatives to the ISMS Council on Governmental Affairs, Council on Economics and Peer Review, and Committee on Governmental Health Program Reimbursement, with the understanding that they will be responsible for their own travel expenses.
- Invite the ICMA president to attend ISMS Board meetings as an observer.
- Invite ICMA members to attend the annual ISMS Leadership Conference.
- Add ICMA members to the ACTION REPORT and ON THE LEGISLATIVE SCENE mailing lists.
- Urge ICMA members to recruit key physicians in their clinics for ISMS membership.

The arrangement is expected to improve communications with clinic-based physicians and enable ISMS to draw upon the expertise of clinic managers in dealing with legislation, insurance, Medicare and Medicaid issues.

Appointments and Nominations

Several hundred ISMS members were appointed to one-year terms on the Society's various councils and committees for 1977-78. Appointed council chairmen were: Drs. A. Beaumont Johnson, Elgin, Economics and Peer Review; Eugene Leonard, Rockford, Education and Manpower; Tassos Nassos, Northbrook, Governmental Affairs; Eugene Vickery, Lena, Medical-Legal; Glen Tomlinson, Lincoln, Medical Service; Patrick Staunton, Oak Park, Mental Health and Addiction; and Mack Hollowell,

Charleston, Public Relations and Membership Services. The chairman of the Council on Affiliate Societies will be named at a later date.

Dr. Donald Hanscom, Hinsdale, was appointed an ISMS representative to the Illinois Cooperative Health Data Systems, replacing Dr. Fred Z. White, Chilli-cothe, who resigned.

The following physicians were nominated for membership on the Medical Advisory Committee to IDPA: Drs. William D. Fish, Chicago; Lydia Walkowiak, Chicago; Donald E. Hoard, Chicago.

Elect Dr. Paul to ICCME Board

Dr. Harold Paul, Chicago, was elected to the Board of Directors of the Illinois Council on Continuing Medical Education. He replaces Dr. John Graettinger as the Rush Medical College representative.

Champus Contract

ISMS will contract with either Mutual of Omaha or Wisconsin Physicians Service (WPS) to perform peer review and/or facilities review for the CHAMPUS program. Both organizations currently are seeking designation to administer the program in Illinois. ISMS also will attempt to negotiate a separate contract with WPS or Mutual to perform professional relations activities on behalf of CHAMPUS.

CME Rules and Regulations

Suggested revisions of the proposed rules and regulations for implementing the mandatory Continuing Medical Education Act were approved in principle. The revisions, formulated by the special ISMS Task Force on Mandatory CME, will be forwarded to the Department of Registration and Education and the Medical Examining Committee.

Security of Medical Records

The Board adopted 12 guidelines designed to improve the security of hospital medical records. The guidelines—prepared by the Task Force on Professional Liability—are published in this issue of the Illinois Medical Journal.

Illinois Medical Journal

The Board took the following action concerning the Illinois Medical Journal:

- Authorized the Publications Committee to offer the position of interim medical editor to Dr. Lester King, Chicago, for a one-year period.
- Authorized a 7.75% increase in full-page, black and white advertising rates effective Jan. 1, 1978.
- Retained current subscription rates for 1978.

Hospital Inspections

ISMS supports in principle Illinois Department of Public Health efforts to have IDPH and JCAH hospital inspections conducted simultaneously.

Medicare Reimbursement

ISMS will voice objection to a Bureau of Health Insurance regulation requiring radiologists to indicate on bills the amount of time spent with the patient, and whether that patient was an inpatient or outpatient.

IDPA Drug Manual

The following drugs were approved for inclusion in the IDPA Drug Manual: Com-bipres, Doxidan, Topicort and Lasix Oral Solution.

Seminar on Bioavailability

The Society agreed to help promote a seminar on bioavailability of drugs planned for September by Ciba-Geigy, but declined an invitation to co-sponsor the program.

Clinical Program on Geriatrics

ISMS will conduct a program on "Recent Advances in the Care of the Aging Patient," Sept. 29-30, at the Sheraton-Oak Brook Motor Hotel, Oak Brook. The session will be divided into four clinical areas: (1) Neurology-Psychiatry; (2) Hematology-Surgery; (3) Rheumatology-Infectious Disease; and (4) Cardiology-Respiratory. The AMA and American Academy of Family Physicians each have granted 14 CME credit hours for participation in the program that will be co-sponsored by the AMA Council on Medical Service.

Practice Management Seminar

ISMS and Will-Grundy County Medical Society will co-sponsor a one-day practice management seminar during ISMS' 1978 annual meeting. The one-day session—titled "Establishing Yourself in Private Practice"—will be directed at senior residents and young physicians.

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REPORT

FOR *Illinois Physicians*

Filing Service Reports for Central Certification Accounts

Many large corporations with branches throughout the United States have uniform Blue Cross-Blue Shield benefits for their employees. This is accomplished by our Central Certification system. Under this system, the group's Home Plan administers the program and approves membership. Benefits are paid by the local Plan where the service is provided.

Electronic Data Systems is one such account. The Company has two downtown Chicago locations and 300 employees.

A number of EDS employees have experienced claim problems because of lack of recognition and acceptance of their Blue Cross-Blue Shield card.

This national account card differs from the usual type issued by Illinois Blue Cross-Blue Shield. It carries the words "National Account" inside a map of the United States in the upper right quadrant of the card; the name of the employer is indicated as well as a three letter alpha prefix followed by a three digit number; in this case EDS 400 or ESC 400. Most importantly, Dallas, Texas is indicated since Texas is the home Plan and Illinois Blue Shield must verify membership with Texas before payment can be made to Illinois providers.

In order to insure correct and prompt payment of claims, please file claims for EDS employees using the following guidelines:

1. Complete our regular Blue Shield Service Report form in the usual way.
2. Be certain to enter the correct group and subscriber number from the card. The group number will be either 90800 or 90801 and will be followed by the employee's social security number.
3. All claims should be mailed directly to the Illinois Blue Shield Plan at 233 N. Michigan Ave., Chicago, IL 60601 from whom you will receive payment.

Your assistance will help us in processing these claims through Central Certification and improve service by reducing the time for payment of benefits.

Blue Shield Medical Necessity Program

In May an announcement was made by the Blue Shield Association after consultation with medical specialty groups and health care professional organizations that Blue Shield would no longer routinely pay for 18 named surgical procedures and 10 named diagnostic procedures. The 28 procedures were listed in the May release. At the time of release we also indicated that written justification by the physician will have to be made before payment will be authorized by Blue Shield for any one of the 28 procedures. Soon you will receive information from us listing those procedures again and how to file for payment when you feel that a listed procedure is medically necessary.

In the meantime, if you have any questions relating to this important program, please call your Professional Relations representatives at (312) 661-4489, or write to the Professional Relations Department at Blue Cross-Blue Shield, 233 N. Michigan, Chicago, Illinois 60601.

Reporting Obstetrical and Newborn Care

When a physician renders obstetrical care to the new mother and also care to the newborn infant, separate Blue Shield Physician Service Report forms should be submitted for each service.

It would also be helpful for claim payment purposes, if circumcision of the newborn was submitted on a separate Service Report form, rather than the one submitted for delivery.

Date of Accident Needed on Physician's Service Reports

Most Blue Shield contracts provide benefits for emergency care of accidental injuries which do not require an operative procedure, such as treatment of sprains, contusions or abrasions.

To avoid delay in processing claims, the *date of the accident* must be shown on the Physician's Service Report.

Computer Generated "Insufficient Information" Letters

Whenever there is information lacking on a Medicare 1490 form, the missing information must be obtained before Medicare can process and make payment on the claim.

Since the Medicare program was first implemented, this Part B carrier has made telephone calls to the physicians' offices or suppliers' offices, to request whatever information was needed. Form letters were sent to the physicians or suppliers when the information required was not available by telephone.

In the near future, additional information telephone calls will no longer be made, except in a very few instances. As a Medicare claim is being processed, whatever type of information is lacking will be given a special code. When a diagnosis is not present anywhere on the claim, it will be given a code number "1", for example. If an itemization is needed, a code number "3" will be given. The computer will then generate a letter that pertains to the particular code or codes used. Physicians and suppliers will receive a computer-generated letter requesting whatever information is lacking on their Medicare form. Physicians and suppliers are requested to return the letter with the information requested within two weeks. A special color coded envelope will be enclosed which will speed the information to the proper area. (These envelopes should not be used for general mailing of Medicare forms. Since they are handled in another area, the forms would only be delayed).

If the additional information letter has not been returned to Medicare within two weeks, the computer will generate a second letter. Should it happen that the second letter is not returned with the additional information in two weeks, the claim, or the portion of the claim for which there is insufficient information, will be denied. The following statement will be referred to on the Explanation of Medicare Benefits, which is sent to the patient, or the Medicare Remittance Notice, which is sent to the physicians and suppliers:

"All or part of this claim was denied because of insufficient information. No reply to our request for additional claim data was received. A claim for the denied services may be submitted with the additional information."

The computer generated letter will be used when a signature, either the physician's or the patient's, is missing. On a non-assigned claim, the letter requesting the patient's signature will be sent to the

patient. On an assigned claim, with the exception of a deceased patient or a Public Aid recipient, the letter requesting the patient's signature will be sent to the physician.

Billing for Chemotherapy Treatments

In billing for the administration of chemotherapy drugs, please itemize the charge for the drug(s) *separately* from the office visit and charge for the treatment. The carrier must have this information as part of the charges for *all services* furnished to make proper payment.

Because a significant number of such claims are being received without the charge for the drug included, our claims department requests your cooperation in completing the item to help us reduce payment delays.

In filing the claim, the charges for *each service* should be itemized as follows:

- (1) Office Visit and Examination \$00.00
- (2) IV Administration and Equipment . . \$ 0.00
- (3) Cost of the Chemotherapy Drug(s) . . \$ 0.00

The date of visit should also be included on the statement or 1490 form.

Notices on Laboratory Closings

The Bureau of Health Insurance, Social Security Administration, has issued notices that the following laboratories are closed, and that no payment can be made under the health insurance program for services rendered on or after the effective closing dates. The laboratories are:

General Medical Laboratories, Inc.
914 West Diversey Parkway
Chicago, Illinois 60614
Provider Number: 14-8243
Effective Date: May 1, 1977

Oak Crest Clinical Laboratory
10522 South Cicero Ave.
Oak Lawn, Illinois 60453
Provider Number: 14-8252
Effective Date: December 20, 1976

No longer providing clinical services:
Diagnostic Scanning Laboratory, Ltd.
7640 West Dempster St.
Morton Grove, Illinois 60053
Provider Number: 14-8324
Effective Date: June 25, 1977



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Adverse Reactions: Most frequent adverse reactions are listed below. Some patients taking salicylates develop nausea and vomiting. Hypersensitivity may be manifested by skin rash or anaphylactic reaction. With these exceptions, most side effects occur after repeated administration of large doses; include headache, vertigo, ringing in ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin.

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Warnings: **Drug dependence.** Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to oral narcotics. Subject to the Federal Controlled Substances Act.

Usage in ambulatory patients. Caution patients that these products may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.

Usage in Pregnancy Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.

Precautions: Head injury and increased intracranial pressure. Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal condition. These products or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients. Administer with caution to certain patients such as elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

Adverse Reactions: Most frequently include lightheadedness, dizziness, sedation, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; others include: euphoria, dysphoria, constipation and pruritis.

Drug Interactions: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For symptoms and treatment of overdose and full prescribing information, see package insert.



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Editorials



Is There a Point of No Return?

BY H. CLOSE HESSELTINE, M.D./CHICAGO

"Is There a Point of No Return?" was first presented as an address to the ISMS Fifty Year Club at the 1977 Annual Meeting in April. Several members found Doctor Hesselstine's talk so interesting that they requested publication in the Journal.

An assumption prevails that there should be some point up to which one could go and then retreat to safety, or security. It is recognized in aviation, naval and military endeavors and many other things. Does this apply to medicine and medical care? Let us explore some of the events of the past fifty years and candidly evaluate the extent of betterment and the possibility of returning before we reach the point of no return.

With your cooperation some reminiscence may provoke additions to this session. When we graduated fifty years ago, progress in diagnostic and therapeutic technology were thought possible, but each step was painful, sluggish and filled with doubt. How does that compare with the attitudes of our profession and the public today about the accelerated introduction of new

drugs and altered therapies? To be sure, an abundance of pride and confidence have nurtured and helped to direct our course.

At the time you graduated from medical school, pneumonia was known in the medical fraternity as the "Captain of Man of Death," or the "Friend of the Aged." Teachers averred that the best treatment was a good nurse. Today it is regarded by many only as another disease subject to successful therapy.

Many other changes have taken place. The "common diseases" of childhood have been largely eliminated by immunization and therapy. However, an epidemic could arise should the public become careless and neglect immunization. An ample number of susceptible people could provide the foundation for an epidemic. Indeed, sporadic epidemics have occurred.

Tuberculosis, (the "white plague") was once a most serious illness with considerable mortality. For those who survived, it brought a long confinement—often forcing individuals into other types of work. At the University of Chicago Clinics, we lost one intern annually to this disease for three consecutive years.

As we extend our activities of research, seeking improved methods, or techniques and new agents or combinations, we are perhaps no different than an invading army. We get involved

H. CLOSE HESSELTINE, M.D., is an obstetrician and gynecologist affiliated with Chicago Lying-In Hospital and Christ Hospital in Oak Lawn. A professor emeritus with both the University of Chicago Hospitals and Rush Medical School, Dr. Hesselstine is an ISMS past president and a former chairman of the ISMS Board of Trustees. He has been responsible for development of several clinical instruments and therapies and chairman or member of many ISMS, CMS and AMA Councils and committees.

with logistics, data computation, the problems of frustrating situations. Delayed complications or critically undesirable results may not appear for decades or scores of years later.

Fifty years ago, the introduction of a new drug was heralded as something unusual, often with skepticism, and sometimes with great rebellion. You are acquainted with what has happened in the last score of years. Most of these came about because of good observation, profound thinking and too often by accident. The new concepts arose from ideas and not necessarily from abundance of money. Money was needed to refine techniques and procedures, but the ideas came from astute observation and scientific curiosity to match it. For instance, the development of insulin occurred not in Paris, Berlin, or New York but from a general practitioner. Unaware that many physiologists thought it impossible, he took a reasonable course and, by fortune, his approach happened to work appropriately. You know the result. Have we gone beyond the point of no return?

In the beginning of your careers, blood transfusion was an embryonic concept. One collected it in a citrate fluid and then administered to the recipient. Intravenous fluids were also in the awakening phase; many of us had to make our own.

Do you remember that some forty years ago persons were commonly denied surgery because they were too old? They did not have sufficient stamina for even a moderate surgical procedure. Nor were there the back-up, or supporting agents, such as fluids, blood and medications. Yes, and modern anesthetic agents are now in the scene. Fifty years ago, chloroform, ether, and nitrous oxide existed, and shortly afterward we witnessed the introduction of ethylene gas.

In years past, the population tended to be somewhat controlled through epidemics, pestilences and famines which would annihilate communities or countries. Today, much of this has been changed. The increase in population may be a giant step toward trouble. A lot of good reproductive land is being used for building communities and towns. Are we going toward a point of no return? When push comes to shove, what will take place?

Attitudes have changed in recent years. It was only recently that one would hear the subject of family planning mentioned openly. Up to this time these discussions were held in whispered voice behind silken curtains. Today you know the "openness" of many things. We know of the

management of venereal disease today. When a Vice-President's wife had breast cancer, the frankness with which it was announced made the detection of this condition a straightforward and worthy cause.

The advances in medical science during your professional career have been glorious. We live longer and freer of worry about our well being. But, what has medical science done to retard the loss of trillions of brain cells and to preserve our physical capability? Yes, we are in the midst of the great experiment. How will it come out?

Special medications as sulfonamides, antibiotics, tranquilizers, steroids and hormones have found a place. So have valuable cardiac and respiratory drugs. Yet, we also can remember when children had X-ray treatment of the thymus gland in their early childhood without knowing the subsequent risk of cancer. What will these new products do in 10, 20, or 30 years from now? It is somewhat startling to know that about a million and a half people have cardiac attack every year. Seven hundred thousand of these will die before they get into the hospital and one hundred thousand die within five minutes. Who has a solution?

What about the problem of malignancies? There have been some gains, but is it near the point at which a victory can be claimed?

Another puzzle can be taken from a report by Mortimer Lipsitt of the National Institute of Health.¹ Let us first reconstruct the biologic behavior of the gonads. The female gonad is the principle source of the steroid estrogen. Both the breast tissue and endometrium are target organs. If the concept is valid, then if a carcinogen strikes in the field of target tissues, under stimulation of estrogen, a malignancy is established. Length of time to exposure of estrogen stimulation has some bearing. Thus, girls whose menarche is 11 years, or younger, and women who have a late menopause are more likely to have endometrial, as well as breast carcinoma. Women who lose both ovaries are less likely to have breast cancer than their unoperated sisters.

The male gonad provides the male steroid which points toward the prostate gland as a stimulation of cells therein. Thus, the prostate gland is a target organ and, if under attack by carcinogens, can precipitate malignancy. Lipsitt adds further support to this view by the statement that not one Eunuch has been known to have prostatic cancer. Does this mean that the respected gonad, while providing for the next generation, also assumes the grim and morbid

role of contributing, in part, to the removal of the host? Is this the point of no return?

What about our organ transplants? How many of you dreamed of an organ transplant from human to human fifty years ago? Not only transplants, but parts, as a new hip, or the by-pass operation for heart disease, or a functioning kidney for a non-functioning one?

Did bountiful money bring these changes about? Indeed not, it was ideas, skills, competence and enthusiasm that made the dream a programmed reality. What of our future? How many of you would like to hazard a guess of what the next breakthrough will be? What, or who will it involve? With addition, modification, or other manipulation of genes and chromosomes to the master computer DNA of the species in question—what will be an end result? The colon bacilli have been studied for their DNA structure. The virus Phi X 174 has 5,375 nucleotides, or subgene units.² These carry all the genetic information needed for reproduction of this virus when sequenced. When it comes to humans, will robots and Frankensteins come about? Have Maurice Wilkens³ and others opened Pandora's box? Can the manipulated DNA molecule be returned to normal, or are we becoming victims of our own destructive curiosity? What about the

transplant of a small normally fertilized ovum from the uterus of the natural mother, or from a test tube, to a surrogate mother? Will it be normal? Is another fifty years going to be as startling and as unpredictable? Yes, is there a point of no return?

Surely, you are thankful for the special privilege of living in the greatest of all times of medical history. Let us have courage to proceed, but pray for wisdom, guidance and sufficient judgement to move at a proper cadence. Let us use a quote from an unknown author for guidance "Look well to this day, for yesterday is but a dream and tomorrow is a vision; but today, well lived, makes every yesterday a dream of happiness and every tomorrow a vision of hope."

In closing we take from the last part of an old Irish prayer "... may the Lord hold us in the palm of His hand until we meet again." ◀

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PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

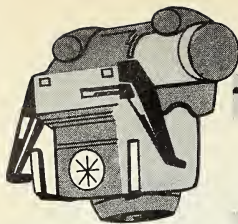
The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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the view box

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Figure 1

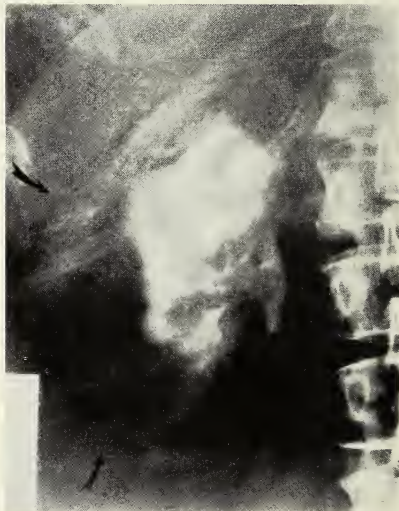


Figure 2

Patient is a 57-year-old female with a rather long history dating back to 1970 at which time she had a biopsy diagnosis of non-Hodgkins lymphoma. In 1971 her right kidney was displaced to the flank by enlarged lymph nodes. Following radiation the kidney returned to its normal location; however it was somewhat shrunken in size. At current admission the IVP demonstrated stones in the region of the renal pelvis on the right side and poor excretion on the pyelogram. A retrograde (Figure 1) was done followed by an angiogram (Figure 2), followed by a 5 second computerized body scan, (Figure 3) Obvious finding was a mass which appeared to be subcapsular compressing the surface of the kidneys.

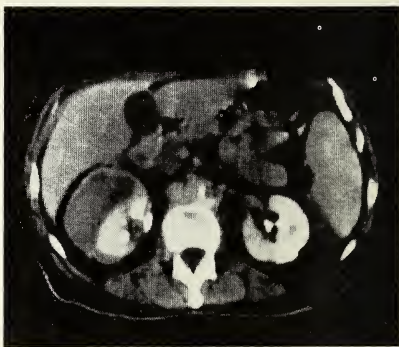


Figure 3

What's your diagnosis?

1. Xanthogranulomatous pyelonephritis
2. Perinephric abscess
3. Subcapsular hematoma
4. Recurrent lymphoma

(Continued on page 115)

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Editorial Comment

The Eye Trauma Center

A New and Necessary Health Care Designation

BY BURTON M. KRIMMER, M.D./CHICAGO

Dramatic improvements within the past few years in diagnosis and management of ocular injuries have necessitated a change in our health care system. It is possible to preserve the vision of numerous patients with early referral to a designated eye trauma center. Skilled personnel are limited, specialized instruments expensive, and facility utilization is restricted. Care and attention must be given to the number and location of existing systems that have been developed exclusively for this purpose. It is my opinion, as well as that of numerous academic leaders in ophthalmology, that it would be appropriate to designate specific hospitals throughout the state as "Eye Trauma Centers." Facilities with trained personnel specializing in the management of ocular trauma would be chosen for centers.

Recent articles in American and British literature have noted improved prognosis of perforating ocular injuries and reduced danger of sympathetic ophthalmia resulting from new management modalities. In the past, the dread effect of sympathetic ophthalmia was a major problem. (The term refers to an inflammation in the uninvolved eye following inappropriate treatment of a perforating injury to the opposite eye.) Lacking alternatives, enucleation of the injured eye was performed in those severely affected to

avoid the effects of sympathetic ophthalmia. The improved prognosis for this condition is contingent upon early diagnosis, prompt surgical intervention, utilization of modern surgical instrumentation, accurate wound repair, and the prolonged use of topical and systemic steroids to reduce inflammation.

Preservation of visual function through repair of direct eye injuries receives the highest priority in the order of management. It must not be forgotten, however, that injuries involving delicate structures supporting and protecting the eye are of utmost importance as well. Recent improvements in management of injuries involving the eyelids, lacrimal apparatus, extraocular muscles, and orbital bones attest to this fact.

The most vital reason for designation of Eye Trauma Centers is prompt referral to avoid late complications. These include glaucoma, low intraocular pressure, cyclitic membranes, and tractional retinal detachment, which so frequently accompany severe ocular trauma, and appear with a disproportionate severity in children. The new instrumentation in the hands of trained ophthalmic surgeons permits early intervention, extensive reconstructive surgery, and in many instances, avoids these late complications. Many eyes can be salvaged through the initiation of these new forms of treatment.

Recent Advances

Several major technical advances in the field of ophthalmology are primarily responsible for

BURTON M. KRIMMER, M.D., is an associate clinical professor in Ophthalmology, affiliated with the Abraham Lincoln School of Medicine, University of Illinois Eye and Infirmary, in Chicago.

the adoption of a new approach to ocular injury management.

1. Binocular operating microscopes with associated microinstruments and ultrafine sutures: This equipment permits careful and accurate wound closure as well as visualization of intraocular structures through the cornea, major advances in anterior and posterior segment surgery.

2. Ultrasonography: This technique can be used to determine the precise location of intraocular foreign bodies. In addition, it provides the surgeon with information regarding the position of structures in the posterior segment of the eye when obstructed from direct view by a cataract or vitreous hemorrhage.

3. Vitreous and retinal surgery: The development of miniature motorized cutting instruments, incorporating continuous infusion and suction mechanisms, has revolutionized the management of intraocular injuries. The application of cryosurgery and laser treatment has also contributed to the management of retinal injury.

4. Ophthalmic plastic and reconstructive surgery: Led by a small dedicated group of subspecialists, successful repair of eyelids, lacrimal apparatus, and orbital structures has been substantially improved. The availability of appropriately trained professional personnel in an Eye Trauma Center is essential.

The practicing clinical ophthalmologist is the primary source of eye health care in Illinois. Trained to diagnose and treat all eye diseases and injuries, he will be further aided by referring those cases requiring specialized eye care to appropriate eye centers. The designation of Eye Trauma Centers is a necessary component to our health system, based on need and availability of services.

Because of the sophisticated nature of the equipment, its expense, and the personnel required for its operation, it is not possible for all hospitals and health facilities to provide these services. Although eye injuries remain a serious and important health problem, they do not occur with a frequency that requires the development of an unregulated number of centers. The identification and full utilization of existing facilities will assist in determining future needs.

Conclusion

It is the purpose of this editorial to urge concerned groups of physicians and lay people to

recommend the identification and designation of Eye Trauma Centers in the state of Illinois. Highway markers, hospital signs, and listings of the centers in all health, police, and fire facilities would be invaluable aides to immediate access.

In recent years, the State of Illinois played a leadership role in the establishment of Trauma Centers that were capable of handling serious injuries and mass disasters in designated hospitals. The concept of Eye Trauma Centers is an extension of this, and should be coordinated with these facilities where possible. In all likelihood, it will not be feasible for every designated Trauma Center to have an Eye Trauma Center. This is an additional reason for clear identification of those locations that are capable of providing complete eye care for eye injuries.

Reference

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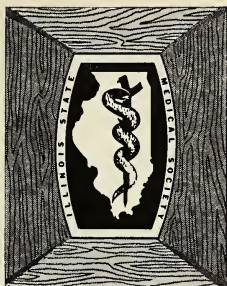
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Illinois Medical Journal

Vol. 152, No. 2, August, 1977

A Comparative Study

Operative Mortality of Coronary Bypass Surgery

BY EUGENE H. SCHMITT, M.D. AND EDWARD H. SHARP, M.D./ROCKFORD

A retrospective study of the operative and long-term mortality of the first 413 patients who underwent Coronary Bypass Surgery (CBS) in Rockford, Illinois, from July 1970 to January 1, 1976, is compared with results of CBS at fourteen university centers. This comparison is to ascertain if CBS can be carried out with relative safety in a non-university community hospital.

In Rockford, the total operative mortality (in-hospital death) for all patients who underwent CBS was 5.1% (21 of 413). If the resuscitative cases and cases where CBS was done with an associated procedure (such as valve replacement or aneurysmectomy) are excluded, total operative mortality was 2.9% (11 of 373). In fourteen surgical series at university centers, the operative mortality ranged from 1.2% to 12%.¹⁻¹⁴

Coronary bypass surgery can be carried out in a non-university community hospital with an operative mortality rate that compares favorably with rates at university centers.

The past ten years have seen a marked increase in the number of thoracic surgeons trained to perform open heart surgery. While the large university medical centers still perform most open heart operations, recent data indicate that an increasing number of coronary bypass procedures are being performed by university-trained cardiovascular surgeons in community hospitals. Using operative mortality and postoperative complications as criteria, investigators have found both acceptable and unacceptable results of myocardial revascularization performed

in community hospitals.¹⁵⁻¹⁷

The Committee on Coronary Bypass Surgery has stated that physicians at a given institution should be doing at least four to six open heart cases a week to remain proficient.¹⁸ Data from 1975 shows that the Rockford cardiovascular surgeons averaged three open heart cases a week divided between two community hospitals. Since the Rockford group did fewer than four to six cases per week, this study addresses the question of whether open heart surgery can be performed in a community setting with an operative mortal-

ity comparable to that reported by the university medical centers.

Method

Rockford, a community of 150,000 in northern Illinois, is located about 90 miles equidistant from three large medical centers. Four cardiovascular surgeons and seven cardiologists, all Rockford private practitioners, cared for the patients.

All patient charts were reviewed and pertinent data placed on IBM punch cards for statistical analysis. A follow-up questionnaire was sent to 311 patients operated on before January 1, 1975. A second and even a third letter was sent to those who did not respond to the previous letter. The remaining patients were located by telephone or by contacting the referring physician or place of employment. Follow-up information was obtained on 100% of the patients.

Patient Population

Between July, 1970 and January 1, 1976, 403 patients had coronary bypass surgery in Rockford and ten subsequently underwent a second coronary bypass operation, for a total of 413 operations. The age at operation ranged from 29 to 74 years with a mean age of 53 years. Of the patients, 345 (85.6%) were male and 58

(14.4%) were female. There were eight males and two females who underwent a second operation. There have been 119 single, 227 double, 65 triple, and 2 quadruple bypass procedures performed. The number of bypass grafts per patient averaged 1.9 and changed from 1.7 in 1970 to 2.0 in 1975.

In 1971, five patients underwent a Vineberg procedure. In the remaining patients the conduit for revascularization included 108 internal mammary to coronary artery anastomosis, and 663 reversed saphenous vein bypass grafts. The 663 saphenous vein grafts can be subdivided: 254 to the anterior descending, 226 to the right or posterior descending, 182 to the circumflex, and one to the left mainstem coronary artery. The first internal mammary to coronary artery anastomosis was done in November, 1972. The internal mammary to coronary artery anastomosis was combined with a single saphenous vein bypass graft in 55 cases and with a double saphenous vein bypass graft in 14 cases. In 4 instances, a double coronary bypass was performed using both internal mammary arteries. An associated procedure, such as mitral or aortic valve replacement, aneurysmectomy or closure of a ventricular septal defect, was performed in 37 (9%) of the patients. A resuscitative procedure was performed in three patients when medical treatment of a cardiac arrest was unsuccessful and

OPERATIVE MORTALITY BY YEAR

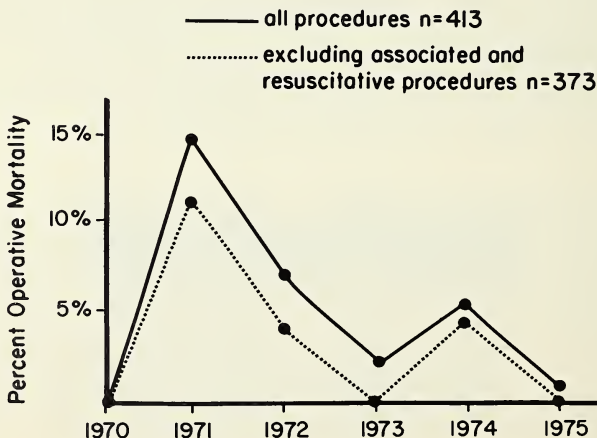


Table 1
OPERATIVE MORTALITY BY YEAR

	1970	1971	1972	1973	1974	1975	Total
All Procedures	7	47	77	81	99	102	413
Operative Deaths	0	7	6	2	5	1	21
Excluding Associated and Resuscitative Procedures	7	36	69	72	89	100	373
Operative Deaths	0	4	3	0	4	0	11
Associated Procedures*	0	11	7	8	10	1	37
Operative Deaths	0	3	2	1	1	0	7
Resuscitative Procedures*	0	0	1	1	0	1	3
Operative Deaths	0	0	1	1	0	1	3

*Not on Graph

the patient was taken to surgery while cardiopulmonary resuscitation was being performed.

In the majority of cases, the decision relative to operative or non-operative management of a patient was made at a weekly cardiovascular conference. The conference was consistently attended by cardiovascular surgeons and cardiologists.

Operative Technique

A median sternotomy was performed and the patient given 3 mg. of heparin per kilogram of body weight. Cardiac bypass was established by placing an arterial cannula in the ascending aorta and two venous cannulas through the inferior and superior vena cavae into the right atrium. The left ventricle was then decompressed with a catheter. Mild hypothermia (32°C) was used.

All coronary bypass operations were performed using a Med-Science® heart-lung pump and Bentley® disposable oxygenator. Oxygen was supplied at the rate of one to two liters per liter of blood flow. For the first few cases, the prime solution for the pump was two liters of 5% glucose in water with 25mg of heparin added per liter. Later, the prime solution consisted of one and one-half liters of 5% glucose in water, a unit of heparinized (20mg/unit) whole blood, and 40gm of mannitol. An average of two units of blood each containing 20mg of heparin and one half gram CaCl was added as necessary during the procedure. Frequent analyses of electrolytes and blood gases were performed.

Results

The total operative mortality (death prior to hospital discharge) was 5.1% (21 of 413). Excluding patients who underwent an associated or

resuscitative procedure, the operative mortality was 2.9% (11 of 373). Figure 1 depicts improving operative mortality over the five year period. Table 1 is a breakdown by year of the results in Rockford.

There was a continued improvement in operative mortality despite an increase in multiple bypass procedures from 1970 to 1975. The one operative death in 1975 was a patient taken to surgery after a cardiac arrest in the angiographic lab. The two other patients who underwent resuscitative procedures in 1972 and 1973 also died.

Operative mortality can be related to several variables. A Chi Square analysis found no significant difference ($p > .05$) in operative mortality as related to age, sex, or first procedure as related to second. There was a significant difference ($p < .05$) in operative mortality when related to number of vessels grafted, and operative mortality without an associated procedure as compared to instances when an associated procedure was performed.

When operative mortality was related to the number of vessels grafted with the exclusion of associated and resuscitative procedures, there was a 0% (0 of 98) operative mortality for single coronary bypass procedures, 2.9% (6 of 209) for

Table 2
SURVIVAL RATES

	All Patients	Excluding Patients Who Underwent Associated Procedures
One year survival	93% (202/217) *	94% (183/195) *
Two year survival	90% (122/136)	93% (112/121)
Three year survival	84% (46/55)	87% (40/46)
Four year survival	92% (11/12)	91% (10/11)

*(Alive at follow up/total patients followed up)

double bypass procedures and 7.6% (5 of 66) for triple or quadruple bypass procedures. Operative mortality was 2.9% (11 of 373) without an associated procedure and 18.9% (7 of 37) with an associated procedure.

Cause of In-Hospital Death

All patients (100%) operated on prior to January 1, 1975 have been followed-up for an average of 24.4 months (range 3 to 56 months) from the date of surgery. Patients unable to sustain function without the heart lung machine constituted the largest number of in-hospital deaths.

Causes of in-hospital death for the 21 germane patients were: failure to sustain function off pump (7); Myocardial infarction (M.I.) (5), Cardiogenic shock (2), Pulmonary insufficiency (1), Renal failure (1), Pulmonary emboli (1), Renal failure, proteus septicemia (1), Pulmonary edema, myocardial ischemia, dissecting aortic aneurysm (1), exsanguination, after mediastinitis and empyema (1) and M.I., stroke, and congestive heart failure (1).

The survival rates of patients at least one, two, three and four years past surgery as of March, 1975, are presented in table 2, and results of a questionnaire sent to patients on symptomatic relief of angina and current work status are listed in table 3.

Comparison With Other Studies

Table 4 demonstrates that operative mortality at fourteen university centers ranged from 1.2% to 12%.¹⁻¹⁴ There are variations in the patients who are included in the series at the different centers. Several included patients who underwent associated procedures and others excluded these patients.

Three series were not directly compared with

Table 4
OPERATIVE MORTALITY OF CORONARY BYPASS SURGERY AT UNIVERSITY CENTERS

Studies including associated procedures		
	Patients	Operative Mortality
Stanford ³	400	6.5%
Marseille, France ⁶	67	10.4%
Paris, France ⁷	200	7.0%
Hahnmann ¹¹	100	12.0%
Rockford	413	5.1%
Studies excluding associated procedures		
	Patients	Operative Mortality
Cleveland Clinic ¹	4,935	1.3%
University of Miami ²	242	5.7%
Texas Heart Institute ⁵	1,289	7.1%
St. Lukes Hospital, New York, New York ⁹	476	2.1%
Duke ¹⁰	392	11.2%
University of Toronto ¹³	880	4.5%
University of Washington ¹⁴	156	7.3%
Rockford	373	2.9%

Series not directly compared with Rockford's statistics

	Patients	Operative Mortality
Yale ⁸	100	9 %
New York University ¹²	448	6.2%
Harvard ⁴	330	1.2%

Rockford's statistics since two^{8,12} included only elective cases. The third excluded patients operated on for concomitant valvular heart disease, those who had acute myocardial infarction with cardiogenic shock or those who had severe compromise of left ventricular function primarily with symptoms of congestive heart failure.⁴

In the studies reviewed, the reported operative mortality does not always include the initial cases of this surgical procedure at the institutions. For example, one study reported in the title a 0.8% operative mortality but excluded all associated procedures as well as their first 100 cases in which there was a 7% operative mortality.⁹

Discussion

If coronary bypass surgery can be performed in a community hospital with operative mortality comparable to that at the university centers there are distinct advantages. The patient remains in the familiar setting of his own community where friends and relatives can visit.

Table 3
SYMPTOMATIC RELIEF POSTOPERATIVELY FOR ALL PATIENTS n = 291

Angina improved	85% (244/287*) †
Frequency of angina	
free of angina	57% (162/285)
once a week or less	19% (54/285)
at least once a week but not every day	16% (46/285)
once a day or more	8% (23/285)
Work (postoperatively)	
full time	63% (179/284)
part time	11% (31/284)
not working	26% (74/284)

*discrepancy in numbers between all patients and total patients responding is due to 17 responses in which the patient left the question blank or gave an unclear answer.

† patient responses/total patients responding

Continuity of care and a close interaction can be maintained between family physician, local cardiologist and cardiovascular surgeon during preoperative evaluation, surgery and follow-up.

This study points out that a requirement of four to six coronary bypass procedures per week is not necessary to obtain satisfactory results. Groups with fewer cases per week can successfully carry out procedures requiring cardiopulmonary bypass.

In Rockford, there has been a continued improvement in the rate of operative mortality despite an increase in multiple bypass grafts. Increased experience and improvements in operative technique and patient care probably have contributed to the decreasing operative mortality over the past five years.

The significant increase in operative mortality when multiple bypass grafts are used can be attributed to diffuse disease with impairment of myocardial function. A significant increase in operative mortality resulted when an associated procedure such as aneurysmectomy or valve replacement was performed. This can be attributed to the second disease process, probably secondary to a previous M.I. and/or concomitant valvular disease.

The indications for operation and patient selection differed greatly at the various university centers. In two studies the selection of patients for coronary bypass surgery included only elective cases. In others, emergency or resuscitative cases were excluded. The exclusion of patients in whom associated procedures such as valve replacements and aneurysmectomies were combined with the coronary bypass surgery has an effect on operative mortality figures, and the difficulty in comparing the groups becomes obvious. A protocol should be developed or existing ones used which would allow separate investigators to make more nearly valid comparisons.

Conclusion

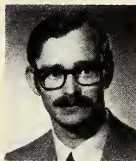
Coronary bypass surgery can be carried out in a non-university community hospital with an operative mortality rate that compares favorably with rates at university centers.

Addendum

The Rockford School of Medicine admitted its first class in the fall of 1972. The authors feel this recent development does not affect the classification of Rockford as a non-university center because the medical atmosphere has re-

mained that of a community hospital with community physicians as faculty.

The same group of cardiovascular surgeons in Rockford began doing coronary bypass surgery in the third community hospital in Rockford during 1976. At the three hospitals a total of 166 coronary bypass procedures were performed during 1976 with an operative mortality of 0.6% (1 of 166). ◀



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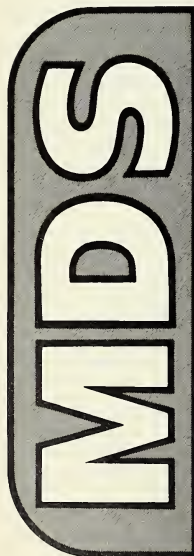
Acknowledgement

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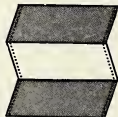
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Traumatic Occlusive Intimal Flap

BY NERCY JAFARI, M.D., RICHARD A. SHAPIRO, M.D., RICHARD H. EVANS, M.D., AND
JOSEPH T. SHERIDAN, M.D./CHICAGO

Two cases of acute arterial occlusion following trauma are presented. In one, the iliac artery was injured by blunt trauma, and in the other, the subclavian artery was injured by gunshot. The arteries were blocked by an intimal flap and both cases were successfully corrected by surgery. A review of the literature revealed 54 similar cases.

Blunt trauma, gunshot wounds and bone fractures may cause intimal injury without any damage to the other layers of the arterial wall. This injured intima can act as a valve, free flap, or because of subintimal hemorrhage, cause occlusion of the vessel.

When the carotid artery sustains the injury, a bruit can be detected or the patient may develop a stroke. Intimal injury of the renal artery may cause hematuria and an intravenous pyelogram

will reveal a nonfunctioning kidney.

Arteriography is one of the most helpful studies for diagnosis and management of this condition. Absence of extravasation of contrast material, ragged intima, evidence of subintimal hematoma, partial or complete occlusion of the lumen, and decrease in concentration of dye distal to the site of injury are characteristic radiologic findings of this syndrome.

At the time of the operation, a dusky-blue discoloration of the involved segment and collapse of the artery distal to the injury is quite diagnostic. Two patients with this particular arterial injury have been treated at Michael Reese Hospital and are being reported.

Case Reports

Case No. 1: A 43-year-old male was involved in an automobile accident and sustained multiple injuries to the face and head. A laceration on the forehead was repaired. One hour later, he complained of cramping pain in the left calf and thigh. At that time, his blood pressure was 170/100mm and his pulse was 120 beats per minute. Physical examination revealed no evidence of intracranial injury; heart sounds and auscultation of the lungs were normal; the abdomen was slightly distended and bowel sounds were hypoactive. Both upper extremities were



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normal. The left leg felt colder than the right. The femoral, popliteal and pedal pulses were absent on the left. Aortic angiography via right femoral artery was performed and complete occlusion of the left common iliac artery was demonstrated (Figure 1).

Five hours after injury, surgical exploration of the abdomen showed a tear in the mesentery with approximately one liter of fresh and clotted blood in the abdominal cavity. The bleeding was controlled. The bifurcation of the aorta was exposed; the right common iliac appeared to be normal, but the distal left common iliac artery was collapsed with bluish discoloration from one cm distal to the bifurcation of the aorta down to the origin of the left internal iliac artery.

A longitudinal arteriotomy was performed. Circumferential intimal disruption was seen with complete occlusion of the vessel. Arterial reconstruction was accomplished using an eight mm Dacron® graft for an end-to-side aorto-external iliac by-pass prosthesis.

At the completion of anastomosis the pedal pulse was quite strong, and the leg became warmer. The postoperative course was uneventful except for transient weakness in the left, lower extremity from which there was complete recovery in one month. There have been no symptoms since.

Case No. 2: A 50-year-old male was admitted to Michael Reese Hospital with a gunshot wound to the left supraclavicular region. The exit of the bullet was in the posterior chest on the left side at T3 level. He complained of weakness and cramps in the left arm, but sensation in the left arm was intact. Radial and ulnar pulses were present, but weaker than on the right.



Figure 1

Arteriogram showing complete occlusion of the left common iliac artery.

Chest X-ray revealed no evidence of hemo- or pneumothorax. Angiography through the left brachial artery was performed and segmental disruption of the intima in the subclavian artery was demonstrated with no extravasation (Figure 2). Within three hours of the injury, exploration of the subclavian artery thru a left supraclavicular approach was performed. After the clavicle was divided, the typical appearance of intimal

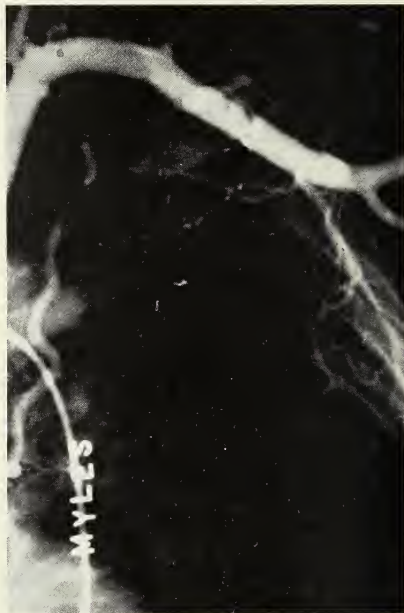


Figure 2

Left subclavian arteriogram demonstrating segmental disruption of intima.

injury with no evidence of extravasation was seen.

The external layers of the artery were intact. Dark blue intraluminal and subintimal thrombus was noted. Upon opening the artery and resection of the involved segment (1cm in length), the intima was seen to be disrupted 60% of the circumference of the artery. The injured segment was resected and continuity was re-established by end-to-end anastomosis. The injured brachial plexus, which was one cm from the

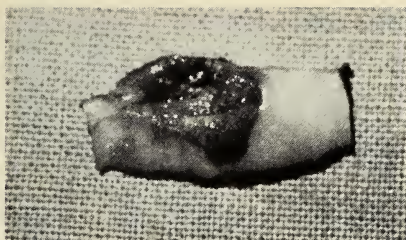


Figure 3

Resected segment of the left subclavian artery (case 11) showing disrupted intima. Specimen has been opened longitudinally.

arterial injury, was debrided and primary repair was performed (Figure 3).

Reduction and fixation of the clavicle was performed using through-and-through wire sutures. On follow-up two months later, the patient had good pulses in both radial and ulnar arteries and improvement in strength and range of motion of the hand.

Discussion

The purpose of this review is (1) to emphasize the existence of isolated intimal injury with intact adventitia causing partial or complete arterial occlusion; (2) to avoid a false impression of arterial spasm which delays management of a patient with serious arterial injury; and (3) to analyze the significance of the appropriate diagnostic and therapeutic measures.

A review of the literature reveals 54 cases of intimal injury by a variety of trauma causing similar pathophysiology. In 1942, Hirshburg and Soll¹¹ reported a 48-year-old male who developed fragmentation of the intima of the renal artery following blunt trauma. In 1956, Elliot⁵ described a patient with an intimal flap of the brachial artery. In 1967, Yamada and associates²⁹ reviewed the literature for reports of carotid artery occlusion due to acute nonpenetrating trauma to the neck. They noted lack of appreciation of the clinical course—that is gradual progression of neurological signs—as a major factor in poor outcome. They recommended early angiography and immediate operation for removal of the obstruction. Grablowsky et al.⁶ studied renal artery thrombosis due to blunt trauma. They found that the lesion is usually unilateral, and all patients presented with hematuria. Intravenous pyelography, renal arterio-

graphy and surgical exploration were recommended.

The mechanism of isolated intimal injury, secondary to direct trauma or deceleration, is probably acute angulation and traction on the artery at a point of fixation near its origin with rupture of the least elastic layer of the arterial wall, the intima.

In a review of the literature, only 54 cases were found which fulfill the criteria of this syndrome and some were considered to be arterial thrombosis. Blunt trauma was responsible for 70% of the cases. The most common site of injury was the renal artery.

Treatment consists of restoration of continuity in the occluded artery. The technique of repair is dependent on the site of injury and the extent of the arterial damage. Primary end-to-end anastomosis, autogenous vein graft prosthetic graft and intinctomy (with or without tacking the intima) seem to be in order. ◀

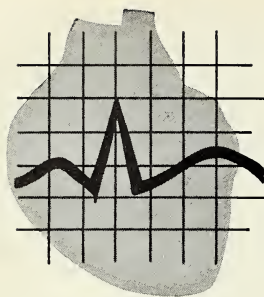
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A complete list of references for "Traumatic Occlusive Intimal Flap" may be obtained by writing the Illinois Medical Journal, 55 E. Monroe Street, Suite 3510, Chicago, 60603. Additional statistical data is available from the authors upon request.

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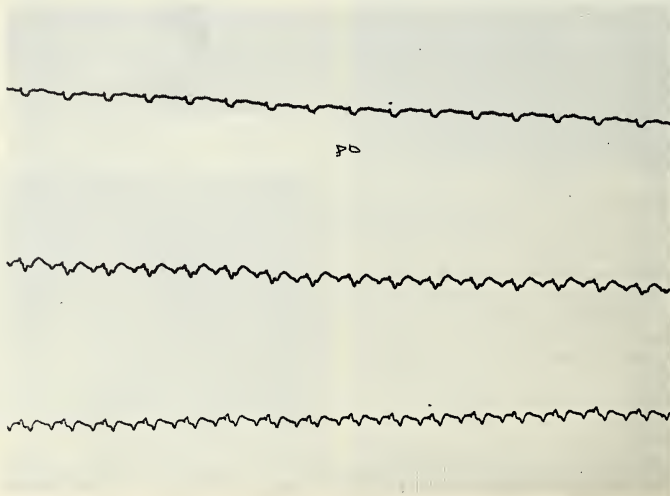
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A forty-eight-year-old woman presented for examination because of a rather insidious onset of pretibial edema and an increase in abdominal girth. Her weight had increased by fifteen pounds in nearly two months. She had a 25 year history of rheumatic heart disease. Five years earlier she had undergone open heart surgery and mitral valve replacement for symptoms of recurrent pulmonary edema. She had been doing well with a much improved exercise tolerance. Her only complaints were peripheral edema, a swollen abdomen, and weight gain. Her medications were Digoxin 0.25 mg/day and Coumadin 5 mg/day. This lead I, II, III rhythm strip was obtained.



Questions:

1. The ECG shows:

- A. An accelerated idioventricular rhythm at rate of 100/minute.
- B. Atrial flutter with 2:1 atrioventricular block.
- C. Atrial tachycardia with 2:1 atrioventricular block.
- D. Sinus node reentry rhythm.
- E. Junctional tachycardia with aberrant intraventricular conduction.

2. Treatment should include:

- A. Discontinuance of the Digoxin.
- B. An increase in Digoxin for treatment of her heart failure.
- C. Diuretic therapy.
- D. An evaluation of her prosthetic mitral valve.
- E. Digoxin blood levels.

(Continued on page 147)

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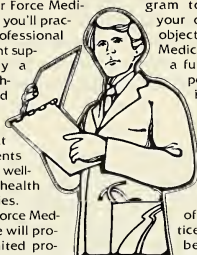
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Recurrent Osteomyelitis of the Sternum

By BENJAMIN EMANUEL, M.D. AND NORMAN YOUNG, M.D./CHICAGO AND DALLAS

A case of sternal osteomyelitis introduced by bone marrow aspiration in a patient with chronic ulcerative colitis is presented and the literature reviewed. Sternal osteomyelitis is more frequently seen in adolescent heroin users, following bone marrow aspiration or median sternotomy in cardiovascular surgery. Immediate surgical drainage and proper antibiotic therapy after identification of the bacteria is mandatory for successful therapy.

Acute osteomyelitis, although a less serious threat to life today than prior to the discovery of antibiotics, is still an important cause of disease and disability in children.¹ Compared to the more frequent involvement of the distal femur, proximal tibia or proximal humerus, osteomyelitis of the sternum in adults and children is rare.^{2-4,9} A case of osteomyelitis of the sternum following bone marrow aspiration in a patient with ulcerative colitis prompted this report.

Case Report

A 16-year-old caucasian male was admitted to the Edgewater Hospital in 1965 with a diagnosis of idiopathic thrombocytopenia and ulcerative colitis. Ulcerative colitis was diagnosed four years previously, by barium enema and proctoscopy. He was treated by diet, azosulfadine and intermittent steroids. There was no family history of bleeding disorders.

Physical examination revealed an emaciated boy with purpuric lesions on his legs and trunk. The remainder of the examination was normal.

Laboratory results revealed normal urinalysis, hemoglobin of 9.5gm/100ml, hematocrit of 33% and a white count of 9,400 with a normal differential. He had a platelet count of 110,000, a normal coagulation time and slightly prolonged bleeding time. Blood electrolytes and urea were normal. Capillary fragility test was negative, as were three LE preparations. A sternal bone mar-

row revealed a mild erythroid, myeloid hyperplasia and an increased megakaryocyte. His steroid dosage was increased to 20mg of prednisone QID from 10 mg TID, and on the fifth hospital day his bleeding time and platelet counts were normal. A month later he was readmitted following pain and tenderness on the right upper part of his sternum and frequent bloody stools. Physical examination revealed a 5x3cm, tender, inflamed, firm area over the right upper part of the sternum from the 3rd to 5th ribs with a tiny scar from the previous bone marrow aspiration.

Laboratory data revealed a white cell count of 8,540 with 36% neutrophilia and 41% bands and hemoglobin of 11.8gm/100ml. His electrolytes and platelet count were within normal limits. X-rays of his sternum revealed an area of rarefaction in the upper part of the sternal body about 1.5cm in diameter (Figure 1) and a soft tissue swelling around it. He was treated with azosulfadine 0.5mg QID orally and 1000mg of staphicillin q6H intravenously. Four days later the abscess was incised and drained. The culture revealed staphylococcus aureus coagulase positive. Three days after surgical drainage, prosthaphlin 1.5gm TID was administered intramuscularly and chloromycetin 0.5mg q6H was given orally.

Four days later, it appeared that the wound was not healing properly. Consequently, the patient received external saline irrigation of the wound and Keflin 2gm QID intravenously. Repeat X-rays of the sternum showed no change from previous films. On the eighth postoperative day cholormycetin was stopped. His bloody diarrhea stopped and he was discharged in good condition on the 21st post-operative day on 10mg of prednisone daily.

One year later, the patient was readmitted following a sternal blow resulting in reinfection. An examination revealed a swollen lump 2x3cm

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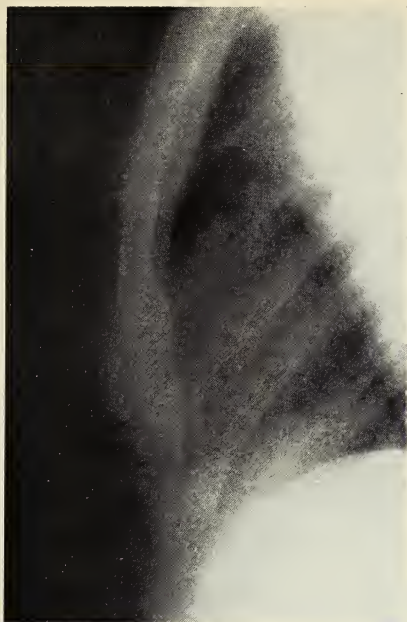


Figure 1

Soft tissue swelling and beginning destruction of sternum.

mediastinitis, pleuritis or liver abscess. Since 1926, only two additional reports of sternal osteomyelitis appeared in infants and children.^{8,10}

Since the introduction of antibiotics the incidence and etiologies of sternal osteomyelitis has drastically changed. Sternal osteomyelitis has been reported with increased incidence following thoracic surgery and open heart surgery.^{2,4,9} The organisms frequently involved were monilia,³ pseudomonas species of *Staphylococcus aureus*.^{4,9}

Sternoarticular septic arthritis has appeared in adolescent heroin users more commonly than recognized earlier. Injection of contaminated heroin appears to have resulted in hematogenous spread by such organisms as pseudomonas aeruginosa and *Staphylococcus Aureus*.⁷

We were unable to find a report of sternal involvement following a bone marrow aspiration. Our patient also had a rare association of idiopathic thrombocytopenia and ulcerative colitis,

over the right side of the sternum and a fever of 101 rectally. Sternal X-rays revealed an area of rarefaction and destruction in the sternum. Dr. M. O. Tachdjian, Head of Orthopedic Surgery at Children's Memorial Hospital of Chicago, was consulted and because of the danger of perforation into the mediastinum, he suggested curetting of the sternum. The parents refused. He was then treated successfully with intravenous prostaphlin and was discharged five days later.

A similar third admission occurred a year later again following trauma to his chest. He received treatment of prostaphlin intravenously 1 1/2 gm for one week. The patient has been well now for the last five years, although still suffering from his ulcerative colitis.

Discussion

Prior to the antibiotic era sternal osteomyelitis in infants and children was rare.¹ Only nine patients from the age of 4 weeks to 18 years old were reported.² All but two patients died from

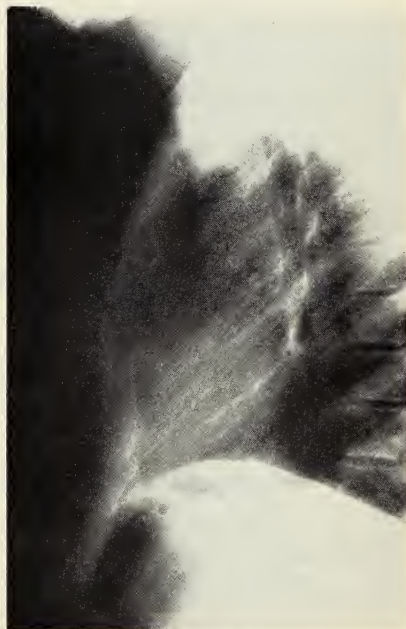


Figure 2

Osteomyelitis of sternum with destruction of sternum in midportion.

and has been on extended steroid therapy. It is possible that the longstanding ulcerative colitis may have altered the host defenses and that the corticosteroids that the patient received depressed his cellular immunity. (Although Feigin and Shearer¹¹ have recently shown that ulcerative colitis does not appear to predispose the host to infections, but treatment with longterm corticosteroids does.)

In a literature search we were unable to find a report devoted to summarizing the clinical laboratory and therapy of pyogenic sternal involvement. Some information however, can be obtained from single case reports in the literature. Our case occurred 10 years ago, and the mode of therapy should be changed in view of recent antibiotics.

In cases of suspected sternal osteomyelitis, a good previous history and suitable radiographic examinations are essential for early diagnosis. The use of bone scan may be beneficial for early detection even prior to radiographic demonstration. An immediate surgical drainage is mandatory, while antimicrobial therapy should not be instituted until the microorganism has been identified and sensitivity to antibiotics were performed.

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Prostaglandins: A Review

By W. S. M. ARRATA, M.D. AND
ALBERT Y. M. TSAI, M.D./CHICAGO

Prostaglandin (PG) is the generic name for a group of fatty acids which are related in chemical structure but produce diversified, and often opposite biological responses on different systems of the body.¹⁻⁴

Alteration of tissue concentration of prostaglandins has been associated with a variety of pathologic conditions, and lead to the speculation that prostaglandins may be involved in a number of disease processes. The potent activities of the natural prostaglandins and their analogues lend themselves to the application as pharmacologic agents.

The essential fatty acid precursors of prostaglandins are stored as phospholipids or sterol esters in the cell membranes. However, esterified fatty acids in the phospholipids cannot serve as precursors to prostaglandins.⁵ They must first be hydrolyzed into free fatty acids by the action of phospholipase A, which may be activated by diverse stimuli, including physiologic (nerve stimulation), physical (trauma), chemical (drugs),

inflammatory (bacterial infections), and immunologic (allergens).

The conversion of the essential fatty acids to prostaglandins is catalyzed by a microsomal enzyme system, the "PG synthetase." This enzyme complex is present in most tissues and can be inhibited by essential aminoacid analogues and many non-steroidal anti-inflammatory agents, such as indomethacin and aspirin.⁶ In fact, there is evidence that the anti-inflammatory activity of these agents may be a result of prostaglandin formation inhibition.

Since the prostaglandins are rapidly metabolized by various tissues, notably the lungs, the liver, and the kidneys, their biologic half-life in circulation and systemic effects are very brief.

Biological Effects of Prostaglandins

The prostaglandins have extremely diverse biologic activities. Differences exist not only among groups of prostaglandins, but also among members of the same group. A particular biologic effect of a given prostaglandin may also vary with the tissue or organ system under consideration. Be that as it may, prostaglandins have two predominant biologic activities—a smooth muscle effect and a hormonal action effect.

Cardiovascular and Renal Systems

The primary effect of the prostaglandins on the cardiovascular system is alteration of the vascular tone. Although vascular effects of the prostaglandins vary among the different regions of the body, in general, PGE and PGA cause vasodilation, hence hypotension, whereas PGF's cause vasoconstriction and therefore hypertension in high dosage.

The PGE's are not effective antihypertensive



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agents due to their rapid inactivation when administered systematically. On the other hand, PGA, which is metabolized less rapidly, effected the fall of blood pressure to normotensive levels in hypertensive patients⁷ with concomitant diuresis and natriuresis. The hypotensive effect of PGA was not significant in normotensive subjects. The therapeutic value of PGA's is not yet firmly established because of their rapid metabolism and gastrointestinal and central nervous system side-effects.

Respiratory Tract

The human lungs are not only active metabolic organs for prostaglandins. They also contain high concentrations of PGE₂ and PGF_{2α}, the former being found in the bronchial wall and the latter in the parenchymal tissue. PGE₂ induces bronchodilation and PGF_{2α} bronchoconstriction by action on the smooth muscle. An imbalance between PGF_{2α} and PGE₂ has been proposed as a possible etiology of bronchial asthma because of their opposing effect on the bronchial tree. Administration of PGF_{2α} brought about asthma-like bronchoconstriction in healthy volunteers,⁸ and the PGE's have been used in aerosol form to relieve bronchoconstriction in asthmatic patients.⁹

Gastrointestinal Tract

Prostaglandins are normally found in the gastrointestinal tract and their release can be enhanced by various stimuli including vagal stimulation. They cause abdominal colics and diarrhea.

PGE's inhibit gastric secretion but enhance fluid and electrolyte secretion from the small intestines. Cholera toxin stimulates prostaglandin production which may be responsible for the clinical symptoms the toxin produces.

The effect of prostaglandins on secretory activities of the gastrointestinal tract is believed to be mediated through cyclic AMP, although the reduction in mucosal blood flow secondary to the hypotensive activities of the prostaglandins may play a significant role. PGF_{2α} which does not cause hypotension, is also devoid of inhibitory action in gastric secretion. The possible role of the prostaglandins in the genesis of peptic ulcer remains to be clarified. It is generally accepted, however, that the gastric symptoms produced by prostaglandin antagonists like aspirin is due to lack of prostaglandin modulation in gastric secretion. The beneficial effect of the prostaglandins in prevention and treatment of

ulcerative diseases in animals has been demonstrated¹⁰ but their therapeutic value in humans remains to be established.

Hematopoietic System

The prostaglandins affect platelet aggregation, erythropoiesis and physical characteristics (and hence fragility) of the erythrocytes.

PGE's and PGF's are normally present in the platelets. Production of prostaglandin can be stimulated by thrombin. While PGF's have not significant demonstrable effect on platelet aggregation, PGE₁ and PGE₂ have an inhibitory activity.¹¹ Although PGE has been shown to have a protective effect on the development of cerebral vein thrombosis in rats, clinical application for prevention or treatment of thromboembolic disorders in humans has not been established. It is, however, being used to enhance platelet recovery in blood banking.¹²

PGE₁ induces swelling of the erythrocytes while PGE₂ inhibits it.¹³ PGE's have been implicated in potentiating intravascular hemolysis and sickle cell crisis. The possible therapeutic value of prostaglandin synthesis inhibitors or antagonists in sickle cell crisis has been suggested but not established.

Inflammation and Fever

While some prostaglandins such as A₁ and F do not induce inflammatory changes, others, notably PGE's, do. PGE₁ and E₂ provoke hyperemia, edema, pain and leukocyte migration when injected into tissue¹⁴ or body cavities, suggesting that the inflammatory and immunologic responses may be mediated by these prostaglandins. Significant increase in prostaglandin concentration has been observed in inflammatory tissues and exudate. Fever and shivering can be produced in animals by injecting either endotoxin or PGE₁ into the cerebral ventricle.¹⁵ Symptoms induced by endotoxin can be reduced by aspirin whereas those by PGE₁ cannot. This indicates that these responses to endotoxin are mediated by PGE, possibly in the hypothalamic centers. The anti-inflammatory and antipyretic actions of aspirin and aspirin-like drugs may be attributed to their ability to decrease prostaglandin formation.

Reproduction

Although prostaglandins of the E and F series have been shown to stimulate release of gonado-

tropins in intact animals, evidence of their physiological role is still lacking.

There are data suggesting that the prostaglandins play a role in ovarian function. Indomethacin suppresses ovulation by preventing rupture of the follicles,¹⁶ but not their luteinization or ovum maturation. It seems, therefore, that prostaglandins are required to facilitate release of the mature ovum from the follicle.

An *in vivo* luteolytic effect of exogenous prostaglandins has been observed in most subprimate species.¹⁷ The luteolytic effect is indicated by a decrease in progesterone production in pseudopregnant animals or by spontaneous pregnancy termination following the administration of prostaglandins. Prostaglandins of the E and F series are generally luteolytic and PGF₂α the most potent. In subprimate species the life span of the corpus luteum is profoundly influenced by presence or absence of the uterine corpus. Luteal function can be prolonged by hysterectomy. It has been suggested that in these species the endometrium releases a luteolytic substance (believed to be a PG) that regulates the functional life span of the corpus luteum. In subhuman primates and humans, the role of prostaglandins in corpus luteum function is less certain since hysterectomy does not significantly affect luteal function, although the uterus is capable of prostaglandin synthesis.

Prostaglandins are present in human menstrual discharge. PG contents in the human endometrium vary with the particular phase of menstrual cycle.

The one pharmacologic effect of the prostaglandins which has extensive clinical application is their activity on the contractility of the uterine myometrium. Although there are conflicting data on the effect of the prostaglandin on contractility of myometrial strips from nonpregnant uteri, both PGE's and PGF's stimulate contractile activity of the pregnant uterus. The potency is different among prostaglandins and is related to the gestational age. PGE₁ and E₂ are of about equal potency but are 40 times that of PGF₂α which is in turn, eight times that of PGF₁α. This property of the prostaglandins has been used in the three phases of gestation—for menses induction in the first trimester, pregnancy termination in the second trimester, and finally labor induction at term.

Early first trimester pregnancy termination was accomplished with the administration of PG by different routes. These include intrauterine, intramuscular, vaginal, oral or intravenous. Pri-

mary prostaglandins or their analogues were used. In most of these studies, success rate varied from 75 to 96%.¹⁸ High-incidence side-effects included vomiting, diarrhea, severe abdominal cramps and fever. The intravenous route of administration was complicated by the highest rate of side-effects.¹⁹

In the second trimester prostaglandins can be used intraamniotically. They are as effective as hypertonic saline and avoid such saline complications as maternal coagulopathy, hypernatremia and myometrial necrosis.²⁰

Labor induction at term has been successfully achieved with PGF₂α or PGE₂ administered intravenously or orally. However, the side-effects and complications are too numerous.²¹ These methods have not superseded the use of oxytocin at term and have not gained wide acceptance. ◀

References

A complete list of references for "Prostaglandins: A Review" may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago, 60603.

Viewbox

(Continued from page 90)

DIAGNOSIS: *Subcapsular hematoma with nephrolithiasis and chronic pyelonephritis.*

In addition the patient had hemorrhagic infarction of the kidney. This is an interesting case in that it utilizes several modalities to arrive at a pathologic diagnosis. The retrograde pyelogram suggested that this patient had a large calculus in the renal pelvis with a large subcapsular collection. This probably represented fat with infection suggesting that the most likely diagnosis should be xanthogranulomatous pyelonephritis. The angiogram demonstrated the large subcapsular collection and rather contracted kidney which again suggested severe infection. The 5 second CAT scan graphically demonstrated the low density subcapsular mass of the right kidney which measured the equivalent of fluid density, therefore it eliminated the possibility of a solid mass, or a collection of fat which would have a different tissue density measurement. These findings were corroborated by the surgical specimen which revealed a large subcapsular collection of blood in a chronically infected kidney with infarction of the kidney as well.

Bone Erosions Associated With Intracranial Arteriovenous Malformation

BY BEHROOZ AZAR-KIA, M.D., F.R.C.R., ENRIQUE PALACIOS, M.D., AND
ROBERT DANLEY, M.D./MAYWOOD

Dilated vascular channels of the vault of the skull due to feeding and draining vessels are well known features of an arteriovenous malformation (AVM). Erosion at the base of the skull without dilatation of the vascular channels of the vault is not a common finding on plain radiography with these malformations and has received little attention in the literature.

The purpose of this paper is to present an intracranial arteriovenous malformation presenting with erosion of the sella turcica and the cervical spine, along with computerized tomography and angiographic confirmation.

Case Report

A 16 year-old-male was admitted for evaluation of headaches which would occur approximately once a month and lasted 12-24 hours. The patient would experience flashing lights in the left eye and develop throbbing headaches in the right temporal area. This was associated with nausea and vomiting, and after sleep, the headache would be gone. No neurological deficit was described with these headaches. Three weeks prior to admission, he had a similar headache, which lasted for one week. He described numbness of the lips and a left hemianopsia.

Physical Examination: The patient was a well developed and well nourished male with a normocephalic head. A bruit was heard over

the right eye, right carotid, and right parieto-temporal area. Pupils were equal and reactive to light. Visual field examination revealed a superior left quadrant defect. Optic fundi appeared normal and showed no vascular changes. Deep tendon reflexes were equal bilaterally. Cranial nerves were grossly intact. There was no evidence of sensory or motor deficit.

Electroencephalogram showed depression of background amplitude and relatively severe slowing over the right hemisphere, mainly posteriorly.

Plain roentgenograms of the skull revealed erosion of the anterior portion of the floor and the dorsum of the sella turcica resulting in a J-shaped sella. (Figures 2 and 6B) Also noted was widening of the right carotid canal and right superior orbital fissure. (Figure 3) Cervical spine roentgenograms revealed widening of the foramina transversaria and the intervertebral foramina. (Figure 1)

Computerized tomography of the head revealed a large lesion in the right temporo-parieto-occipital region, (Figure 4A) the density of which was enhanced following infusion of contrast media. (Figure 4B)

A selective right internal carotidangiogram showed a markedly tortuous and dilated right carotid siphon causing erosion of the dorsum and the floor of the sella turcica. (Figure 5A, B) An arteriovenous malformation was seen to be supplied by several of the distal branches of the middle cerebral artery with profuse and tortuous

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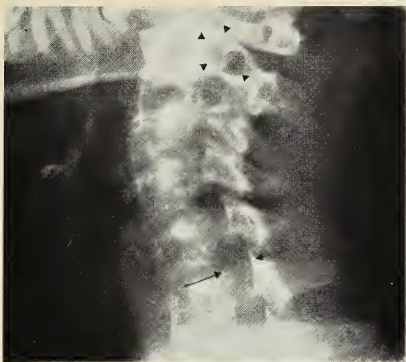


Figure 1

Oblique view of the cervical spine showing widening of the intervertebral foramina (arrows) as well as widening of the foramina transversaria (arrow heads).

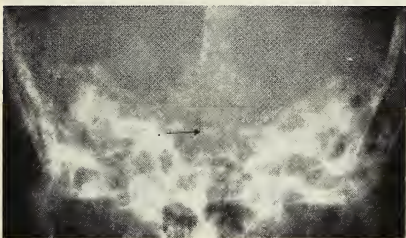


Figure 2

Townes view of the skull demonstrates erosion of the right side of the dorsum sella (arrows).

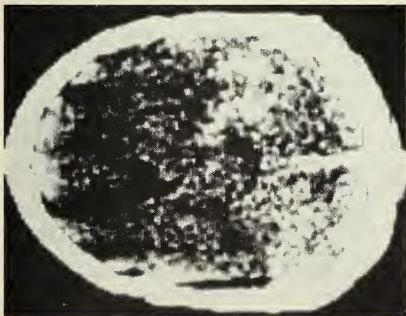


Figure 4A

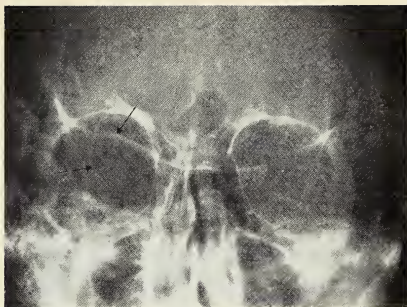


Figure 3

Caldwell projection of the skull reveals widening of the right superior orbital fissure with elevation of the lesser wing of the sphenoid (arrows).

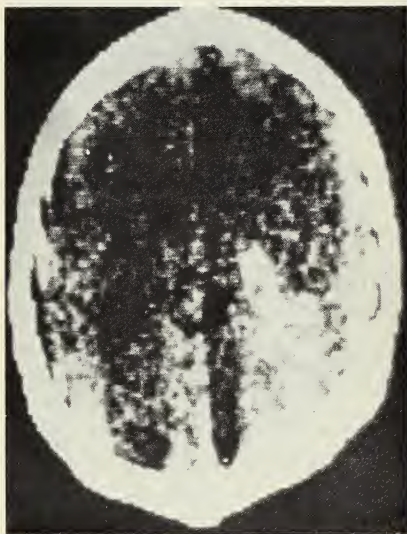


Figure 4B

Figure 4 (A & B)

Computerized tomography shows an area of increased density in the right occipital region. Enhancement of this density is seen following injection of contrast material (arrow heads).

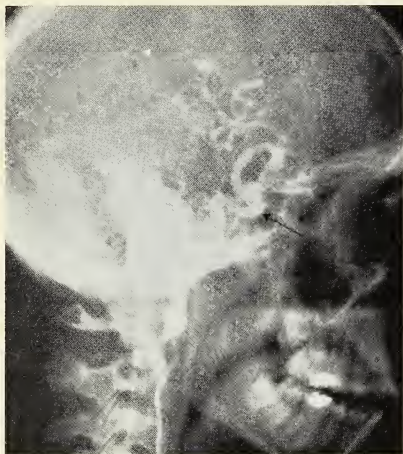


Figure 5 (A & B)

AP and lateral views of a selective internal carotid injection show a pressure defect on the sella turcica caused by the dilated internal carotid artery. (arrows) Also seen are abnormal vessels extending into the orbit, resulting in widening of the superior orbital fissure (arrow heads).



venous drainage. A selective external carotid angiogram revealed dilated and tortuous ascending pharyngeal and middle meningeal arteries supplying the AVM. Selective right and left vertebral angiograms demonstrated greatly enlarged and tortuous vertebral arteries causing widening of the foramina transversaria and intervertebral foramina of the cervical spine. (Figures 6A, B) These vessels from the vertebral system were a major supply of the arteriovenous malformation located in the right temporoparieto-occipital region. The posterior meningeal artery from the vertebral system was also enlarged supplying the lesion. (Figure 6) There were no feeding vessels from the left carotid artery.

The lesion was considered to be non-resectable and the patient is being treated symptomatically.

Comments

Enlarged foramina of the cervical spine are most commonly associated with neurofibromatosis, meningiomas, or rare intraspinal neoplasms.^{1,13} Localized vascular lesions such as AVM's and aneurysms may be the cause of erosions of the pedicles and vertebral bodies of

the cervical spine. Congenital absence or hypoplasia of the pedicle may produce a similar appearance. Erosion of the cervical spine by tortuous vertebral arteries of arteriosclerotic, luetic,⁶ or idiopathic nature have been previously reported.^{1,2,8,11,13} In post-mortum studies, up to 26% of the cadavers had tortuous vertebral arteries, many with bony erosions. Less well documented are bony erosions due to AVM's, or by dilatation of the feeding arteries.^{4,9}

Besides demonstrating enlargement of the foramina transversaria and intervertebral foramina, our case also demonstrates erosion of the sella turcica and the right superior orbital fissure. We believe erosions in these locations may be characteristic features produced by dilated vertebral and internal carotid arteries, strongly suggesting the presence of AVM's prior to arteriography.

Similar changes may be seen by dysplastic bony lesions in neurofibromatosis.^{5,10} However, to our knowledge, enlarged foramina transversaria and carotid canals have not been reported in neurofibromatosis and these may be differential features. ◀



Figure 6 (A & B)

AP and lateral views of a vertebral injection shows a markedly dilated vertebral artery causing widening of intervertebral foramina (arrow) and foramina transversaria (crossed arrow). Note also the erosion of the anterior aspect of the sella turcica represent-

ing a J-shaped sella (double-crossed arrow). Note the AVM supplied by the posterior cerebral artery and the enlarged posterior meningeal artery (arrow heads).

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Malaria in Illinois

By RAJINDER GULIANI, M.D., and THOMAS A. REARDON, M.D./CHICAGO

Before 1965, the annual incidence of Malaria in the United States remained fairly stable at less than 200 cases per year.¹ During the late 1960s and early 1970s, returning Vietnam veterans created a renewed interest in this protozoan disease in the United States.² Three recent case histories demonstrated that the practicing physician's diligence and index of suspicion regarding the malarial parasite should not now be relaxed.

Case One

A 24-year-old oriental male native of India was admitted with a 10 day history of intermittent fever. The fever would occur approximately every third day, subside within hours and was followed by profuse sweating. The fever was accompanied by shaking chills, headache, and myalgia. The patient denied any pulmonary or urinary tract symptoms.

Physical examination revealed a moderately built, well nourished male with a temperature of 105°F. Vital signs were within normal limits. Eye, ear, nose and throat examination were unrevealing. There was no lymphadenopathy. Examination of the chest, lungs and heart were within normal limits. There was no hepatomegaly. The spleen tip was palpable below the left costal margin. Hemoglobin was 13.8 gm%, hema-

tocrit 38%, WBC 6,200, segments 66%, lymphocytes 27%, stabs 5%. Urinalysis was normal. Cultures of the urine, blood and sputum were negative. Liver-spleen scan was normal. Peripheral blood smear for malarial parasite (Figure 1) was positive for species *Plasmodium Vivax*. G-6 PD assay was normal.

The patient was treated with Chloroquine suppressive therapy and became afebrile on the second hospital day. He was discharged to follow up on Primaquine therapy for 14 days. The patient was a native of Punjab, a Northern province of India and had migrated to Chicago nine months previously. He gave no history of malaria but had taken prophylactic therapy in the form of Chloroquine in the past.

A search of the medical records for the year 1976 at the Columbus-Cunco-Cabrini Medical Center revealed the following additional cases.

Case Two

A 33-year-old female Asian Indian presented with fever, chills, diaphoresis of four days duration. She had migrated from India four months previously. She had taken two malarial pills on one occasion eight months prior to her immigration. Physical examination other than the fever of 102°F and a functional cardiac murmur was entirely normal. There was no evidence of hepatosplenomegaly clinically. Malaria smear was positive for *Plasmodium malariae*.

Case Three

A 28-year-old male who had arrived from El Salvador, Guatemala, six months previously was admitted with fever of 106°F and history of fever spikes of 104°F for two weeks. Malaria blood smear revealed forms compatible with *Plasmodium Vivax*.

Summary

In 1970, the twenty-fold increase in reported cases of malaria in the United States³ could be attributed to returning Vietnam military personnel. By 1974, the sustained high level of malaria cases exhibited only a 7% military incidence.



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RAJINDER GULIANI, M.D., is a resident physician at the Columbus-Cunco-Cabrini Medical Center in Chicago. Doctor Guliani is former assistant research officer for the Indian Council of Medical Research and Registrar of Medicine in the Post Graduate Institute of Medical Education and Research in Chandigarh, India. Doctor Guliani is particularly interested in both internal medicine and cardiology.

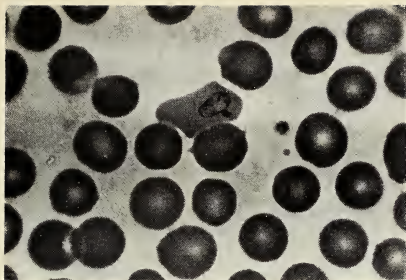


Figure 1

Malaria smear (Wright stain) demonstrating ameboid trophozoite. Note enlargement of infested RBC characteristic of *Plasmodium vivax*.

This increase in civilian cases has been attributed to either recreational travel to endemic areas or to incomplete and inadequate prophylaxis resulting in suppression of recognizable early primary manifestations of the infection.⁴ In addition, emigrants from Southeast Asia, South and Central America may transport the infection to this country. Inadequate prophylaxis in this immigrant population may delay the onset of

symptoms for a period of up to one year following the last possible exposure to malaria.⁵

Infection may be spread to civilian populations through either blood transfusions or the anopheles mosquito vector which is present in the south and western United States. Patients exhibiting illness characterized by paroxysm of rigor, fever and diaphoresis should be questioned regarding recent emigration from or travel to an endemic malarial area. Further, the malarial blood smear should be part of the laboratory workup of such febrile illnesses. ◀

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Obituaries

Dvorak, Emanuel R., Brookfield, died April 24 at the age of 78.

*Fisbel, J. Virgil, Arcola, died June 22 at the age of 80. Doctor Fisbel was a 1927 graduate of the University of Illinois College of Medicine.

*Callati, Cyril M., Chicago Heights, died June 24 at the age of 67. Doctor Callati was a 1936 graduate of the University of Illinois College of Medicine.

*Hagler, Carl W., Quincy, died June 2 at the age of 65. Doctor Hagler was a 1942 graduate of the University of Kansas.

*Hathaway, Earl A., Elmhurst, died June 12 at the age of 54. Doctor Hathaway was a 1946 graduate of the University of Chicago.

Hoffenberg, Nathan L., Chicago, died April 28 at the age of 67.

*Kale, Waman M., Chicago, died March 5 at the age of 48. Doctor Kale was a 1952 graduate of Nagpur Medical College, India.

*Kirshen, Martin, Chicago, died July 2 at the age of 85. Doctor Kirshen was a 1917 graduate of the University of Vienna.

Klein, David, Chicago, died April 13 at the age of 92.

*McGann, Raymond Charles, Mount Sterling, died April 21 at the age of 91.

*Morrill Elizabeth B., Chicago, died June 21 at the age of 89. Doctor Morrill was a 1916 graduate of the Chicago College of Medicine.

Reilly, Richard, Chicago, died June 1 at the age of 51. Doctor Reilly was a 1953 graduate of the University of Chicago.

Sherman, Boudana B., Los Angeles, formerly of Glencoe, died May 9, at the age of 87.

*Starceovich, Paul J., Chicago, died March 3 at the age of 73. Doctor Starceovich was a 1930 graduate of the University of Illinois College of Medicine.

Wexler, Ralph, Chicago, died June 16 at the age of 63.

*Indicates ISMS member.

**Indicates member of the ISMS Fifty Year Club.

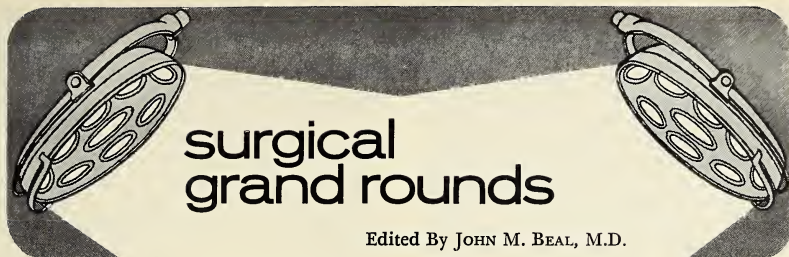
Clinics for Crippled Children Listed for September

Thirty-five clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-five general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be eight special clinics for children with cardiac conditions and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

September 1	Sterling, Community General Hospital
September 1	Effingham, St. Anthony Memorial Hospital
September 1	Lake County Cardiac, Victory Memorial Hospital
September 2	Division Cardiac, U. of I. at the Medical Center
September 6	E. St. Louis, Christian Welfare Hospital
September 7	Springfield Pediatric-Neurology, St. John's Hospital
September 7	Hinsdale, Hinsdale Hospital
September 8	Springfield, St. John's Hospital
September 8	West Frankfort, Union Hospital
September 9	Chicago Heights Cardiac, St. James Hospital
September 12	Peoria Cardiac, St. Francis Hospital
September 13	Peoria, St. Francis Hospital
September 13	Carrollton, Boyd Memorial Hospital
September 14	Carmi, Carmi Township Hospital
September 14	Rock Island Cerebral Palsy, Foundation for Crippled Children and Adults
September 14	Champaign-Urbana, McKinley Hospital
September 14	Centralia, St. Mary's Hospital
September 14	Chicago Heights General, St. James Hospital
September 14	Joliet, St. Joseph's Hospital

September 15	Rockford, Rockford Memorial Hospital
September 15	Elmhurst Cardiac, Memorial Hospital of DuPage County
September 19	Maywood, Loyola Medical Center
September 20	Belleville, St. Elizabeth's Hospital
September 20	Rock Island, Moline Public Hospital
September 20	Decatur, Decatur Memorial Hospital
September 21	Anna, Union County Hospital
September 21	Evergreen Park, Little Company of Mary Hospital
September 23	Chicago Heights Cardiac, St. James Hospital
September 26	Peoria Cardiac, St. Francis Hospital
September 27	Alton, Alton Memorial Hospital
September 27	Peoria, St. Francis Hospital
September 27	Park Ridge Cardiac, Lutheran General Hospital
September 28	Chicago Heights General, St. James Hospital
September 28	Elgin, Sherman Hospital
September 29	Macomb, McDonough District Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local, social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.



Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of April 27, 1976.

Case Report

Hemolytic Anemia with Surgical Significance

Dr. David Katrana: A 58-year-old Caucasian man was in apparent good health until December of 1975, when he noticed increasing fatigue with shortness of breath and substernal chest pain upon exertion, relieved by rest. Progressive bilateral ankle edema appeared and his family noted an increased skin pallor. He was admitted to a hospital in January, 1976.

At that time, the striking findings were related to his blood count. He was found to have hemoglobin level of 5.4 gm and white count of 32,000, 97% of which were lymphocytes. A direct Coombs test was positive. The diagnosis of autoimmune hemolytic anemia secondary to chronic lymphocytic leukemia was made at that hospital and he was treated with chlorambucil, 2 mg/day and prednisone, 10 mg, 4 times/day. Treatment with Synthroid® 0.1mg daily was initiated for suspected hypothyroidism.

The patient did not respond well and his symptoms progressed. He was referred to Northwestern University Medical Center for evaluation and treatment.

When admitted his complaints were weakness,

fatigue and intermittent substernal chest pain on exertion. Review of systems was noncontributory. Physical examination: blood pressure normal without an orthostatic drop; pulse, 110; temperature, 99° and regular; respiratory rate, 20. He was quite pale, mildly obese and in no acute distress. The thyroid was slightly enlarged but without nodules. Chest examination revealed mild cardiomegaly with 2/6 systolic flow murmur at the left lower sternal border. Peripheral pulses were equal and strong bilaterally.

Abdominal examination showed the abdomen to be flat, bowel sounds active and liver edge smooth with a total span of 14 cm. The spleen was palpable, 6 cm below the left costal margin. Rectal examination was unremarkable. Extremities showed bilateral pretibial mild pitting edema. Chest X-ray showed the lung fields to be clear without evidence of hilar adenopathy or pulmonary infiltrates.

Admitting laboratory data was striking: Hematocrit, 12%; hemoglobin, 3.8 gm and his white count was 8,800 with 87% lymphocytes. The peripheral smear showed macrocytosis, poly-

chromatophilia and anisocytosis. His platelet count was 280,000. Urinalysis was unremarkable and was negative for free hemoglobin on multiple samples. Survey 18 was normal except for a total bilirubin of 1.8 mg%; BUN of 29, uric acid of 11.7; albumin of 3.3 gm and LDH was 1,000 units. His reticulocyte count was 57 (normal range 0.5-1.5); serum hemoglobin was elevated at 23 (normal of 0-10). Thyroid studies were normal. Cholecystography was normal. A bone marrow biopsy was performed from the posterior iliac chest. Protein electrophoresis was normal. The dose of prednisone was increased to 20 mg, four times daily and other medications were discontinued.

Splenectomy was recommended. Preoperative preparation included transfusion to elevate his

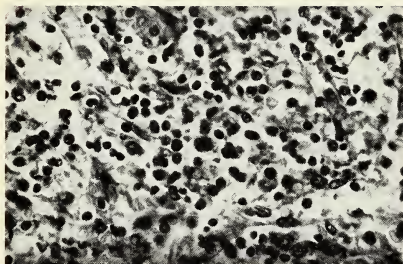


Figure 1

Bone marrow biopsy demonstrated infiltration of lymphocytes, compatible with diagnosis of chronic myelophatic leukemia.

hematocrit, a change in steroids to hydrocortisone and the administration of antibiotics.

Surgery Performed

On the day of operation, his preoperative blood count demonstrated a hematocrit of 33, white count, 4,400 and platelets, 330,000. Splenectomy was performed through a left paramedian incision. The spleen was found large but the operation was accomplished. The liver was biopsied. The patient did well postoperatively. His hematocrit at the time of discharge from the hospital, two weeks later, was 24 and his white blood cell count was 5000.

Dr. Hector Battifora: A representative area

from the bone marrow shows an infiltrate composed predominantly of fairly mature lymphocytes. (Figure 1) These infiltrates were abundant and large and confirmed the diagnosis of chronic lymphocytic leukemia.

The spleen was quite large, weighing 1170 grams. The most significant finding in the spleen was the presence of great numbers of red blood cells within the reticuloendothelial cells which line the splenic sinusoid. In other words, there is a great deal of erythrophagocytosis going on in the spleen.

Second Case Study

Dr. E. J. Smith: A 22-year-old woman was examined by her gynecologist in the 16th week of pregnancy. He noticed splenomegaly and she was admitted to the hospital.

Careful questioning failed to yield a history suggestive of hemotologic disorder. She did not have a family history of splenomegaly or anemia.

When examined, she was found to be 16 weeks pregnant. A large spleen was felt four finger breadths below the left costal margin. Her liver was not enlarged and examination was otherwise unremarkable. Pertinent laboratory data involved the hemotologic system. Hematocrit was 31% at that time and remained between 31 and 33% throughout the pregnancy. Her white blood cell count was 12,000 and platelet count was 320,000. Abnormal findings were a reticulocyte count that varied between 11 and 15%, haptoglobin level was 28, which is abnormal and suggests a hemolytic process. Coombs test, both direct and indirect, was negative and serum bilirubin level was 1.1. Glucose-6PD was normal, as was her hemoglobin electrophoretic pattern. Red blood cell saline fragility was abnormal and the cells lysed in abnormally high concentrations of saline. The peripheral smear demonstrated spherocytosis.

The patient was discharged and followed through a normal pregnancy. A healthy baby girl was delivered at term. This child has been found to have evidence of congenital spherocytosis and is being observed through the Children's Memorial Hospital.

After recovery from the pregnancy, the patient was readmitted to the hospital. Physical findings and laboratory data were essentially unchanged. An oral cholecystogram was normal.

An elective splenectomy was performed, using a left subcostal incision. The spleen was found to be about twice normal size and was removed

without incident. Closure without drainage was accomplished and she left the hospital seven days later.

Her platelet count rose from 320,000 to 900,000, then returned to normal. Hematocrit varied from 31-33 while she was in the hospital.

Discussion

Dr. Ennio Rossi: We have had presented here two interesting cases of hemolytic anemia. In the first case, hemolysis is due to an extracorporeal defect and in the second, hemolysis is due to an intracorporeal defect. Between the two of them, we have excellent examples of the major classifications of hemolytic anemia.

Both patients had splenomegaly and you may hear the term hypersplenism used. Indeed, in the presence of hemolytic anemia, splenic enlargement may occur as a secondary phenomenon due to work hypertrophy, as in the second case. In other words, the spleen itself may not be defective. It may be enlarged only because it has to work harder removing defective red cells. For this reason, it is important to realize that hypersplenism, like any other "ism", is really an idea. It refers to a disturbed relationship between peripheral blood cells and the spleen, but does not tell us which of the two is primarily at fault. Although red cell destruction in the spleen was justification for splenectomy in both these cases, the mechanisms involved were different.

The first case was a rather severe autoimmune hemolytic anemia. The spleen was removed because it was the site of red cell destruction and may have been contributing to formation of the antibody that was destroying the red cells. The fact that the spleen was enlarged was not sufficient indication in itself for splenectomy. However, in this case we also had: (1) a positive Coombs indicating the presence of gamma globulin (presumably antibody) in the red cell surface and (2) a very high reticulocyte count. These findings were consistent with the hyperplastic bone marrow that was described and indicated that the red cells were being turned over extremely rapidly. If we correct the 57% 'retic' count, for the degree of anemia, we still have a reticulocyte count above 20%. In an individual with chronic lymphocytic leukemia (CLL) this is an unusually good erythropoietic response and further supports the conclusion that the rate of red cell destruction must be extremely rapid.

When a patient with CLL presents with autoimmune hemolytic anemia (AIHA), treatment with prednisone, chlorambucil or alkylating agent is indicated. When the AIHA is exceptionally severe, splenectomy in an effort to achieve some degree of immediate decrease in the rate of red cell destruction is justified. It is unlikely that AIHA of this severity would have responded satisfactorily to medical management alone. The severity of the AIHA, the primary diagnosis of CLL and the marked splenomegaly all indicate that the spleen is "defective" and suggests that splenectomy should bring about clinical improvement. But how much clinical improvement should be expected? This is problematic. Removal of the spleen removed a site of antibody production and red cell destruction. However, antibodies may be produced by other lymphoid tissue, and antibody-coated red cells may be destroyed in the liver. Although degree of improvement cannot be predicted with certainty, the maintenance dose of steroids required to control hemolysis should be less following splenectomy.

The second patient has hereditary spherocytosis (HS) which is an intracorporeal abnormality of the red cell. The red cell has a spheroidal shape which hampers its passage through the smaller channels in the vascular tree. As a result, these red cells tend to become trapped in the spleen and the patient, as illustrated in today's case, develops splenomegaly due to work hypertrophy. The spleen normally performs a quality control function and removes abnormal red cells such as spherocytes. The red cell abnormality in HS is genetically determined and unalterable by any direct means. Therefore, the spleen must be removed even though it is not the primary site of pathology.

The normal red cell is a biconcave disc while the spherocyte, as the name indicates, is a sphere. When you look at a normal red cell, you can see a central clear zone. The spherocyte on the other hand is darker, a little smaller and lacking a clear zone it looks like a "little red cannon ball."

A number of laboratory findings characteristic of hemolytic anemia can be found in individuals with hereditary spherocytosis. These include an increased indirect bilirubin, an increased reticulocyte count, and a decreased haptoglobin. There are some interesting features in the history as well. The patient admitted that every time she exerted herself or developed a URI, she would become icteric. However, she did not become particularly ill in association with episodes of

icterus and she soon learned to live with what she and her family thought was a harmless idiosyncrasy. As you can see, nothing I have mentioned thus far defines the disease. What I have described is a clinical constellation of findings that indicates that this patient is a very good candidate for hereditary spherocytosis.

Spherocytes are not able to withstand hypotonic stress as effectively as normal cells. This fact is exploited in the osmotic fragility test which is an important confirmatory test in HS diagnosis. If normal red cells are exposed to hypotonic solutions they begin to swell, imbibe water, and become spheroidal in shape. If the solution is sufficiently hypotonic, hemolysis occurs.

In hereditary spherocytosis, the red cell is spheroidal from the outset. For that reason, such cells are lysed by relatively small decrements of tonicity.

For example, normal red cells begin to lyse in 0.5 gms% NaCl and are completely lysed on 0.4 gms% NaCl. On the other hand, in HS hemolysis begins at 0.7 gms% NaCl and is complete in 0.5 gms% NaCl.

What is the basic fundamental abnormality in hereditary spherocytosis? There is greater red cell sodium-potassium ATPase activity. The red cells also consume glucose and produce lactate more rapidly, indicating that glycolysis is going at a much more rapid rate than normal. Fundamentally, the red cell is excessively permeable to sodium. As a result, greater amounts of ATP are required to maintain the normal cationic composition of the red cell and an accelerated rate of glycolysis is required to provide the ATP. However, this is only a partially effective compensation. Passage through the spleen and prolonged periods spent in splenic stasis compartments debilitate red cells. Removal of a spleen does remove a stress that the hereditary spherocyte finds difficult to withstand. For this reason, a splenectomy in HS is in effect curative.

Possible Genetic Link

Dr. John Beal: Dr. Rossi, what is the genetic pattern? Is this dominant?

Dr. Ennio Rossi: Yes, it is autosomal dominant. Confirmation of the diagnosis in the patient is provided by the fact that her child's diagnosis was made at Children's Hospital, quite independently. Although there is no evidence of the disease in the patient's parents, a spontaneous mutation could explain its presence in the

patient.

Dr. John Beal: But the parents really weren't studied, were they?

Dr. Ennio Rossi: They weren't studied. Historically, we don't have any indication that either of them suffered from anemia. However, your question raises an important point. Possibly, if we did study them, we might find some abnormality that would suggest that one of them had a hemolytic anemia. Hereditary spherocytosis has been discovered as an incidental finding in individuals that were in their 80's. Possibly one of the patient's parents has an extremely mild form of HS.

Dr. John Beal: This was picked up during the patient's pregnancy. Does the disease offer any particular hazard during that time?

Dr. Ennio Rossi: No, I don't know of any particular hazard either to the mother or to the child that would exceed the hazard to a non-pregnant woman.

Dr. Hector Battifora: When should the child have a splenectomy?

Dr. Ennio Rossi: The pediatricians suggested that splenectomy should be deferred until almost 5 or 6 years of age. There have been many publications concerning increased risk of infection in children following splenectomy. There is evidence to suggest that splenectomy in adults may result in some increased susceptibility to infection, particularly pneumococcal infections.

Dr. Donald Casey: It seems odd that after conclusion of her pregnancy and performance of the splenectomy she had no increase in hematocrit.

Dr. Julius Conn, Jr.: We saw her after the pregnancy and hematocrit has been increased since the pregnancy.

Dr. Stuart Poticha: In a case like the first one presented where the bone marrow becomes infiltrated with tumor, the spleen also serves as a source of extramedullary hematopoiesis, but at the same time it can also be destroying red cells. Is there any qualitative test that you do to make sure a splenectomy can be done in that instance? You're not going to make the patient worse off than before?

Dr. Ennio Rossi: A red cell survival with radioactive scanning over the liver and spleen can be done. A short survival with sequestration of radioactivity over the spleen would suggest that the patient would profit from splenectomy. However, I would be more inclined to fear what the spleen is destroying rather than worry about losing what the spleen might be producing. ◀

Doctor's News

OPHTHALMOLOGY CONFERENCE—The Alex E. Krill Memorial Conference of the University of Chicago Department of Ophthalmology will be held October 21 and 22 at the Drake Hotel in Chicago. The Krill Memorial Lecture will be delivered by Paul Henkind, M.D., Ph.D. Other guest speakers include Nicholas G. Douvas, M.D., Richard Green, M.D., Douglas Anderson, M.D., Herbert E. Kaufman, M.D. and Gunter K. von Noorden, M.D., Additional presentations will be given by speakers from the University of Chicago.

Further information may be obtained from Frederick A. Mausolf, M.D., Department of Ophthalmology, University of Chicago, Box 437, 950 East 59th Street, Chicago, 60637.

CME UPDATE—The Department of Registration and Education Medical Examining Committee is moving quickly toward a revised set of Continuing Medical Education regulations. Over the past several months, suggestions from the Illinois Council on Continuing Medical Education were reviewed by the ISMS Task Force on Mandatory CME, whose proposals were approved by the ISMS Board of Trustees in early June and forwarded to the Medical Examining Committee as the ISMS recommendations. Final official regulations are likely to appear by late fall of this year, and reasonable mandatory hours for the interim period (between approval and the 1978 license renewal date) will be announced at that time.

INTERNISTS TO MEET—Hugh S. Espey, M.D., Illinois Society of Internal Medicine president, has announced that the Society's Annual Dinner will be held at 6:30 p.m. on September 10, 1977, at the Drake Hotel in Chicago. Neil Chayet, a nationally prominent attorney with special interests in the legal aspects of medical practice, will be the featured speaker. Mr. Chayet, a frequent CBS radio commentator, will address the controversy surrounding certification and recertification, a subject of particular interest to the many internists facing recertification examinations in October.

The meeting is being held in conjunction with the Illinois regional meeting of the American College of Physicians. For additional information, please call Wendy J. Smith, Illinois Society of Internal Medicine, 55 East Monroe, Suite 3510, Chicago 60603 (312/782-1654).

MALPRACTICE INSURANCE REVISIONS—The classification system for malpractice insurance through the Illinois State Medical Inter-Insurance Exchange (ISMIE) has been revised to reflect the effects of specialty, procedures performed and geographic location. According to Doctor Fredric D. Lake, chairman of the ISMIE Board of Governors, the revisions will provide a fair and realistic reflection of today's malpractice climate, and is the result of an exhaustive review of risk-determining criteria. The new system is more graduated and will take into account the risks inherent to individual practices rather than by specialty, as was formerly the case. The program shows an overall premium increase of only 6.5%, and will result in premium reductions in some cases, such as those who discontinue surgery and other high-risk procedures or practice only part time. Underwriting will continue to be guided by review committees of physicians.

PHYSICIANS IN THE NEWS—The Chicago Medical Society has announced their new slate of officers. **Morris T. Friedell, M.D.**, Chicago, is the new president and chairman of the Board of Trustees for the Society, and **Clifton L. Reeder, M.D.**, Park Ridge, was elected president-elect. Doctor Friedell is president of the Jackson Park Hospital Foundation in Chicago, and Doctor Reeder is chief executive officer and medical director of Bodimetric Profiles Division of the American Service Bureau in Park Ridge. The new treasurer of the Society is **John P. Harrod, Jr., M.D.**, Chicago. Former president **Herschel Browns, M.D.**, Chicago, was recently elected to the ISMS Board of Trustees.

Former ISMS president **Frank J. Jirka, Jr., M.D.**, Berwyn, was named vice chairman of the American Medical Association Board at the convention in San Francisco. . . . **Richard N. Rovner, M.D.**, a Chicago neurosurgeon, has been elected to chair the Department of Registration and Education Medical Examining Committee.

The 1977 Chicago Lung Association Medal for outstanding dedication and service in the fight against lung disease was awarded to **William Lester, M.D.**, Chicago, a professor of medicine at the University of Chicago. The Association has also announced that **David W. Cugell, M.D.**, Evanston, was elected president. Dr. Cugell, a Baxley professor of pulmonary medicine at Northwestern University Medical School, is a staff physician at Northwestern Memorial and Lakeside Veterans Administration Hospital.

A retiring Belleville physician, **Dr. Vivien P. Siegel**, was recently honored at a banquet lauding his 50 years of service at St. Mary's Hospital in East St. Louis. . . . **Jeffrey R. M. Kunz, M.D.**, Berwyn, 1977 graduate of the University of Wisconsin Medical School, has been awarded the first fellowship in the AMA's Dr. Morris Fishbein Fellowship in Medical Journalism Program. Fishbein fellows will participate as senior staff members of AMA publications, and gain practical training in medical publications. Dr. Kunz is the former editor of the medical school newspaper at the University of Wisconsin. . . . **Daniel Offer, M.D.**, Winnetka, has been appointed Department of Psychiatry chairman and director of the Psychosomatic and Psychiatric Institute at Michael Reese Hospital and Medical Center. The position requires supervision of all programs and a large staff, coordination of the Wexler Clinic (the largest out-patient clinic in Illinois) and the Pritzker Children's Psychiatric Unit.

The Chicago Gynecological Society has announced its 1977-78 slate of officers, elected at their June meeting. They are **Albert B. Gerbie, M.D.**, Northfield, president, **Robert E. Lane, M.D.**, Northbrook, president-elect, **Norman R. Cooperman, M.D.**, Chicago, vice-president, **Antonio Scommegna, M.D.**, Chicago, Secretary, **Holden K. Farrar, Jr., M.D.**, Winnetka, assistant secretary and **Philip C. Williams, M.D.**, Chicago, treasurer.

A REMINDER . . . The House of Delegates adopted a resolution at the ISMS Annual Meeting urging physicians to promote and encourage use of the fourth edition of the AMA's Current Procedural Terminology coding system for medical procedures. CPT-4 was endorsed with a note that it included the most comprehensive coding system yet available and had been prepared with the input of all medical specialties.



ICCME: A Valuable Resource

With CME now mandatory for license re-certification, this state's physicians are indeed fortunate to have the Illinois Council on Continuing Medical Education. ICCME is unique—the only such agency in all of organized medicine. It has only one purpose: To develop CME programs that will enable ISMS members to maintain the highest possible standard of care. Four specific services are of particular interest:

- *Your Personal Learning Plan*—A unique handbook that can help you determine your personal learning needs and develop a systematic, efficient program to meet them.
- *How to Start a CME Program*—Designed for hospital medical staffs or local medical societies, this handbook mixes sound educational theory with examples of successful programs now being conducted in Illinois.
- *Workshop in CME Leadership*—A three-hour workshop designed to boost your medical staff or society's efforts to develop a common sense approach to CME.
- *Personal Consultation*—The ICCME staff is available to offer the medical staff, local society or individual physician any assistance that may be needed.

The resources of ISMS and the state's eight medical schools are behind ICCME. Your dues money supports this enlightened program. Why not take advantage of it?

A handwritten signature in cursive script that reads "George T. Wilkins, Jr.".

George T. Wilkins, Jr., M.D.

SYSTEMS IN STRESS

BY MICHAEL S. SHAPIRO, M.D./ELGIN

Philosophy of Therapy

Patients present for therapeutic intervention when they find themselves unable to cope with life stresses by using their usual personal internal defenses or external support systems. When the emotional discomfort has reached a "pain threshold" the individual turns to another person whose skills and knowledge can assist in the re-establishment of an effective approach to life and in the relief of emotional pain. The most effective ways of accomplishing this are: a) evaluating the various support systems which are involved in the individual's social matrix; b) evaluating the personal strengths and weaknesses of the individual; c) intervening to effect a total approach to the presented problems.

The ideal place for such intervention is an outpatient clinic so the patient can make effective life changes while remaining in his/her own environment. In some instances the stresses are too great, the support systems insufficient, the personal disorganization too severe, or the individual's pathology life-threatening. Outpatient intervention may be ineffective and a decision for inpatient hospitalization is made.

Philosophy of Inpatient Hospitalization

Purpose

The purposes of hospitalization are rapid, thorough evaluation and intensive, active treatment. The patient is assisted through the crisis

and expediently returns home. Once the crisis is resolved and the patient discharged, the focus of psychotherapy changes. Long-range psychological and behavioral changes are then emphasized. To accomplish the goals of brief inpatient therapy effectively, a systematic, coordinated treatment plan for the patient *must* be constructed, and actively implemented by all members of a therapeutic team.

Hierarchical Structure of the Unit

Method

A coordinated, unified team treatment effort, mediated through a well-constructed treatment plan is required to guide the patient back to a healthy functional state. To institute such a treatment plan the following factors are required: (1) *all* members of the treatment team are essential and give support to the treatment effort, (2) any break in the team will interfere with the progress of the patient's path toward improvement, (3) intercommunication is an essential part of a smooth functioning working unit, (4) the treatment approach should be patient-centered and not diagnosis-centered.

Organizational Models

There are two previously described models which are not mutually exclusive: (1) the *hierarchical model* (Fig. 1) which grants authority to the most experienced, knowledgeable, and responsible persons for establishment of a treatment plan; (2) the *functional model* (Fig. 2) which stresses that the implementation of the treatment plan requires equal cooperation of all team members. The most effective model assesses the various systems of influence involving a given individual and is designed to improve those component systems which are functioning poorly.

"Systems of influence" include the genetic, biological, intrapsychic, family, marital and interpersonal factors which are important life-factors influencing a patient's adjustment or maladjust-



MICHAEL S. SHAPIRO, M.D., is an assistant clinical professor in the department of psychiatry at the Loyola University Medical Center. He is affiliated with St. Joseph Hospital and Sherman Hospital in Elgin. Dr. Shapiro is also the former director of the psychiatric residency program and psychiatric inpatient services at Loyola University Medical Center.

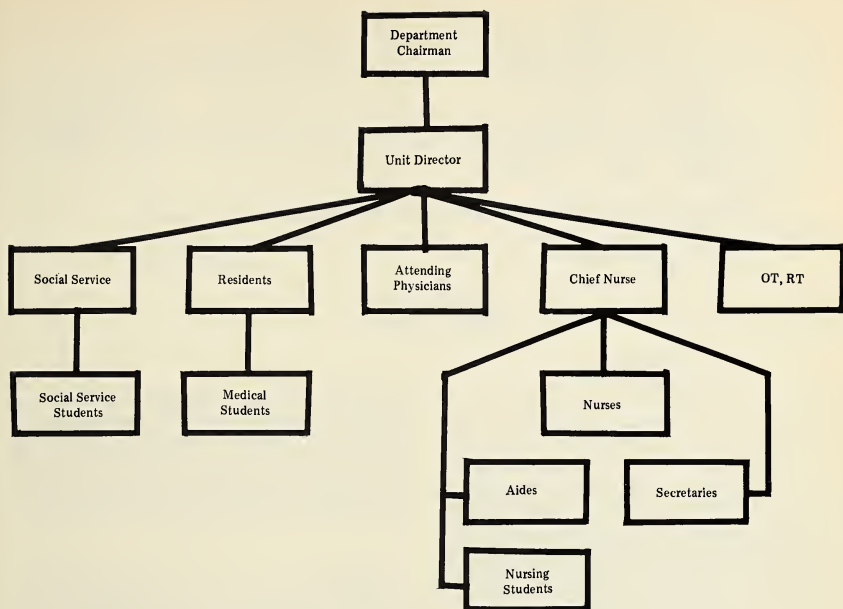


Figure 1
Hierarchical Model

ment to life. The following is an example of the systems approach application.

Example

Mrs. J is a 40-year-old married white female who presents in the emergency room withdrawn, somewhat disheveled and markedly depressed, expressing suicidal thoughts. She states that she has become progressively more depressed in the past month, experiencing anorexia, weight loss of 20 pounds, insomnia, withdrawal from peer relationships, inability to concentrate or perform her normal tasks at home, irritability, threat of dissolution of marriage with fears that her husband has been unfaithful, isolation from her children who are grown and out of the home, and preoccupation with death and suicide. The patient states that she has previously experienced less severe periods of unhappiness. She states that her mother has been depressed and was treated with Tofranil® and psychotherapy. The patient

feels particularly distraught about her inability to function because she was very orderly and organized in the past.

Analysis of Example

The functioning of this individual is dependent upon the interactions of her various systems of influence. Any defect of one component will affect her overall functioning as well as other components. Figure 3 illustrates a model to assess the component systems. With this model, evaluation of the influences upon Mrs. J and treatment formulation are possible.

Evaluation

Genetic

Mrs. J presented with a family history of depression (mother was treated for depression) and a recurrent history of that problem. The genetics of mental illness tells us that recurrent depres-

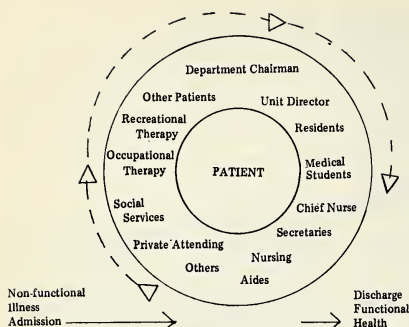


Figure 2
Functional Model

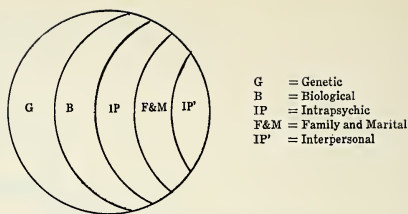


Figure 3
Component Systems

sions are genetically linked. We additionally know that her mother was successfully treated with Tofranil®. Medication response seems to be genetically linked and therefore, treatment with Tofranil® (as opposed to other medications) is indicated. This information, obtained by taking a thorough history, can be useful in diagnosis, prognosis, and treatment as well as genetic counseling.

Biological

Mrs. J. presents with complaints of anorexia, weight loss of 20 pounds, and insomnia. These symptoms are suggestive of a biological component to her depression. A knowledge of the biological model for depression would imply biological intervention, i.e., medication. As already discussed, Tofranil® would be the initial drug of choice. "Biological" implies the overall physical status of the patient should be assessed by a thorough physical examination and appropriate laboratory evaluations, because of the correlation of certain physical disorders which present as psychiatric disorders. For example, hypothyroidism, hypoglycemia or Parkinson's disease present as depression; thyrotoxicosis, amphetamine psychosis, or amygdalar seizures present as mania or schizophrenia. We must also be aware of psychophysiological disorders, conversion reactions and adjustment reactions of illness as components of the biological status of our patient. We must know the effects of pregnancy, the menstrual cycle and menopause in assessing

female patients. We must also be cognizant of the effects of drugs to be able to recognize and treat adverse reactions, addiction, and overdose. As can readily be seen, this area of influence is an extremely important area on which to focus and reinforces the need for the physician as the head of the treatment team.

Intra-psychic

This component is concerned with the traditional psychoanalytic areas of investigation including early childhood experiences, developmental stages, development of defense mechanisms, fixations and regressions, and so on. When dealing with a patient who presents classical symptoms of the "oedipal-conflict" this area needs exploration; and intervention would be primarily psychological.

We also have insufficient data at this point to ascertain which mode of psychological intervention would be most appropriate and expanding the data base would be one of the tasks of intervention.

Family and Marital

Patients commonly present problems centering around the family or their marriage. In dealing with adolescents, the stated patient often is in a scapegoated position in the family, and behavior is representative of inability to understand or cope with the family stresses. This is also true in marital problems where the affective and behavioral symptoms are integrally enmeshed, either causally or consequently, in the difficulties of the marital relationship. In the case of Mrs. J we see that there are marital difficulties hallmarked by fears of her husband's infidelity and frequent arguments. She feels abandoned by her children

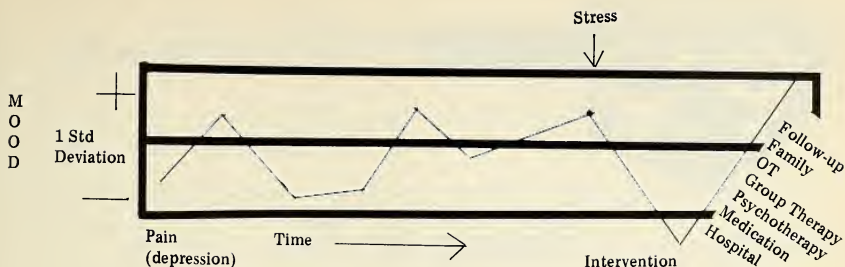


Figure 4
Treatment Model

who were previously part of this support system. It would, therefore, be important to evaluate the marriage and engage the husband and children for the purpose of healing the family and restoring support. This can be accomplished with phone contacts, individual contacts, and family therapy.

Interpersonal

A patient may be functioning well interpersonally at home yet may have severe difficulty with outside interpersonal relationships. As a consequence, she may withdraw, lose confidence, avoid others, have vocational problems, feel isolated and become dysphoric. This seems to apply to Mrs. J, who had withdrawn from peer relationships and become progressively more isolated and depressed. Since we have ascertained the presence of interpersonal problems, part of the treatment would be focused on helping the patient gain confidence in her interpersonal skills by establishing an empathic one-to-one relationship. This might be accomplished by encouraging the patient to participate in group therapy (where she can gain confidence in her ability to relate to others, establish relationships, not feel alone or isolated, and can give of herself to help others). Occupational therapy might facilitate additional confidence in her ability to function via projects, self-care activities, etc.

Treatment

From the preceding evaluation we can now propose a treatment program for Mrs. J. (Fig. 4) We are in the emergency room and have evaluated the data. We first decide to hospitalize the patient, thus removing her from the stressful environ-

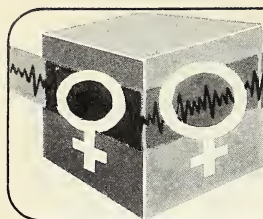
ment. We next decide that the patient is presenting with a genetically-determined depression and place her on Tofranil® to intervene in the biological disruption. We have thus established an empathic beginning psychotherapeutic relationship. We would next start the patient in group therapy and occupational-recreational therapy to help her to expand her self confidence interpersonally and reestablish her previously productive self. We may bring in the family and work toward altering the home environment. Finally, we make *adequate follow-up plans* to provide the patient and/or her family with a resource center or person who could continue the therapy begun in the emergency room by outpatient medication, individual, group or family therapy.

Summary

In order to offer the most effective psychiatric approach to total patient care, a unified, well-planned team effort is needed. The psychiatric team is based on a medical model and utilizes a systems approach to facilitate optimum and rapid change. The hospital is used as a crisis center for brief periods to facilitate reintroduction of the patient into an amended personal support system in the community. ◀

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pulse... of the doctor's wife

MRS. EUGENE VICKERY, Editor

KEY LINES:

Bridging the Gap

By BETTY SZEWCZYK, PRESIDENT, ISMSA

Communication provided an underlying theme for the American Medical Association Auxiliary's 54th Annual Convention in San Francisco. The importance of transmitting ideas, information and feelings was emphasized throughout.

At a workshop called "Bridging the Gap," special emphasis was placed on the communications lag between medical societies and their auxiliaries. The biggest problem appears to be physician lethargy.

Many medical society members fail to realize that the Auxiliary can improve their professional image as can no one else. Informed and enthusiastic auxiliary members can do more in the political arena. They can work with other groups to inform the public about medical schools, doctors' training and unavoidable cost increases. They can educate fellow citizens about other facets of health care and the problems that arise

in delivering it.

Illinois brought two examples of this principle to San Francisco. Mrs. Selig Hodes, Illinois AMAERF Chairman, accepted an award for the largest total money contribution to the national fund: \$157,864.67. Later, Mrs. John Ovitz, immediate past president, presented Illinois' Idea Exchange. Some time ago, Mrs. Eugene Vickery, a past president and enthusiastic safety chairman, printed and distributed food choking posters. Those posters and the safety campaign they initiated, Mrs. Ovitz said, have brought House Bill 13 (Lucky) Heimlich Maneuver Bill, to the Illinois Senate.

We must "bridge the gap" and cooperate in programs, meetings, committees and billing. Medical Auxiliary has a tremendous potential and is eager to have that power unlocked. Come on doctors, turn the key!



The Illinois Delegation joined 251 delegates and 96 alternates at the American Medical Association Auxiliary Annual Meeting in San Francisco, June 19-22. First row, left to right, Mrs. Selig (Evelyn) Hodes; Mrs. Robert (Bea) Hartman; Mrs. John (Jane) Ovitz; Mrs. Edward (Betty) Szewczyk; Mrs. Earl (Jane) Klaren; Mrs. Willard (Ruth) Scrivner; Mrs. Mitchell (Anna) Spellberg. Second row, left to right, Mrs. Eugene (Millie) Vickery; Mrs. Karl (Aggie) Reddies; Mrs. Eugene (Doris) Leonard; Mrs. August (Olivia) Martinucci; Mrs. Howard (Phyllis) Lowy; Mrs. E. A. (Alice) Sullivan; Mrs. Harold (Bonnie) Keegan.

Our Elderly Are Unique

BY ABRAHAM GELPERIN, M.D./MANTENO

What is aging and why are today's elderly remarkable? A brief discussion of the genesis of aging will clarify the fact that they are the ones that did not die, or, that they are the living minority of their peers; the remnants of American or foreign-born infants from the 1870's through 1912. Consider the mortality experiences of a cohort born during that period. In contradistinction, a population of elderly is developing with a significant number of people kept alive by mass use of new vaccines, medical, surgical, and psychologic diagnostic procedures and therapies. Rapid communication, proper nutrition, antibiotics, as well as pure water and safe food are reducing infant, child, and adult mortality to a fraction of the rates that were recorded for the present population of elderly.

Who are today's elderly?

Before attempting to answer the vigorous and at times ascerbic charges, counter-charges and differing demands by government, health providers and the elderly, it is necessary to delineate who these people are. Gerontologists' projections of the expected future elderly population into the year 2000 presume that present experiences prognosticate future expectations. This is the basic fallacy, for the elderly of the future will bear little resemblance to those of the present.

The processes of growing older start with genetics, and include aspects ranging from inherited defects to long-lived grandparents. The newborn develops through interaction with parents, family, visitors, pets, and his total environment. Soon there are peers for play and learning. Friendships are rapidly formed and easily dis-

solved. Young children usually play nicely; acquisitiveness comes soon enough. All the variations between hoarding and ready loaning start early. The framework of character is developing and with it a lifestyle that continues to be modified to varying degrees by life experiences. Major input is received from changes in residence, school, friendship; and in time work, marriage, and family.

Graphs I, II, III, and IV¹ record differences between sexes and in particular, between "white and all other" in American or foreign-born infants between the 1870's and 1920's. Although the composition of society was predominantly rural, deaths from tuberculosis, pneumonia, infant diarrhea, childhood communicable diseases, typhoid, child birth, malaria, pellagra, typhus, influenza, syphilis, war, etc., were ever-present world-wide threats. Those who have reached the geriatric age are the tough as well as the fortunate ones. They had innumerable reasons for dying that carried away the majority of their peers.

Our elderly have brought with them the scars as well as strengths from a lifetime struggle to adapt, to tolerate and be tolerated, to live or

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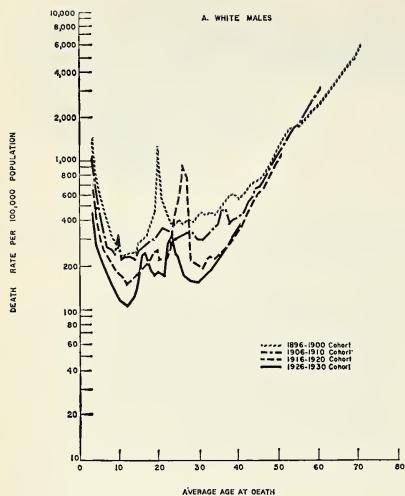


Figure 1. Mortality rates for cohorts born 1896-1900, 1906-1910, 1916-1920, and 1926-1930, by sex, color, and age; death registration States, 1900-1908.

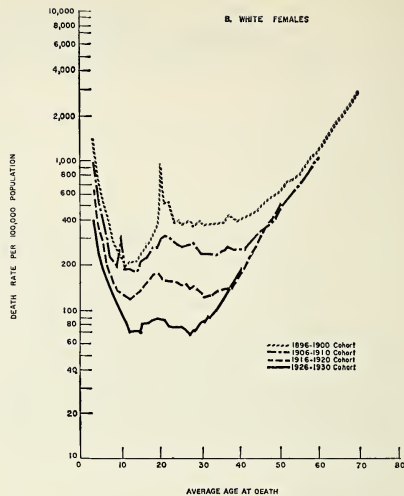


Figure 1. Mortality rates for cohorts born 1896-1900, 1906-1910, 1916-1920, and 1926-1930, by sex, color, and age; death registration States, 1900-1908—Cont.

exist. They do, in the main, get along. We also forget that opportunities for education, even in lower level grades, were not routinely available. Yet, the accomplishments of those generations are quite visible! Coping is the procedure by which a person creates internal and external homeostasis by using developed abilities to mitigate stress, be it pain or joy, disaster or victory, rejection or love. This has been a subject for contemplation by psychiatrists, psychologists, anthropologists, sociologists, philosophers, clergy, etc.

We have been beset by long dissertations on "normal" development and a plethora of case studies of failures. There is no "normal", and fortuitously, there are relatively few "failures". We are informed of the reasons for the disasters. However, it is more fascinating and even practical to realize that the great majority do "as well as can be expected". Most persons of any age somehow manage life's exigencies. The health professions only see those who may come or are sent to us as needing help.

This segment has caused another misconception. They usually have more than one, or many chronic diseases of consequence. The biochemical and physiologic changes that increase as a result of aberrations in the growth and/or maintenance

of cellular function which suggest the process of aging, as well as all major chronic diseases are not unique to the geriatric population. Cardiovascular diseases, hypertension, stroke, osteoarthritis, emphysema, osteoporosis, chronic brain syndrome, dental caries, senility, deafness, and diabetes mellitus, for example, had their genesis many years before that legislated age, 65.

Depression is truly the illness that can develop during later years in our industrialized, youth-oriented society. To be no longer productive as required by the milieu of today can promote emotional disaster. In the rural society, grandpa owned the farm. Way must be made for the young entering the labor market. To be in pasture and in addition have to live with government largess below its designated poverty level can produce feelings of worthlessness, apathy and withdrawal, leading to alcoholism and even suicide.

The major environmental and health care developments that have markedly increased our chances to live are relatively recent and have occurred in spite of markedly increased urbanization. The present, and especially the future population of elderly, is developing a significant proportion kept alive by mass use of vaccines, new medical, surgical, and psychologic diagnostic

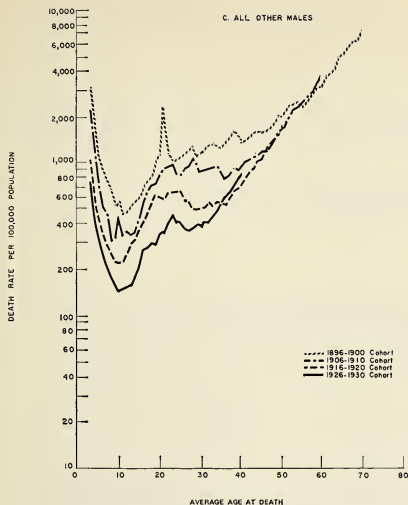


Figure 1. Mortality rates for cohorts born 1896-1900, 1906-1910, 1916-1920, and 1926-1930, by sex, color, and age: death-registration States, 1900-1968-Gov.

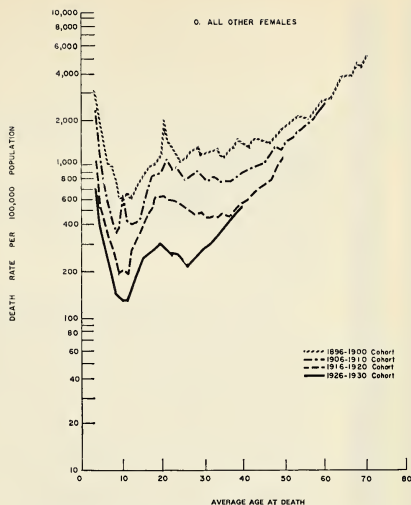


Figure 1. Mortality rates for cohorts born 1896-1900, 1906-1910, 1916-1920, and 1926-1930, by sex, color, and age: death-registration States, 1900-1968-Gov.

procedures and therapies. Rapid communication, proper nutrition, antibiotics, as well as purer water, safer food, and universally available education at all levels for those who desire it, have also contributed. Prevention of death from medical and surgical emergencies, cure of previously incurable diseases, effective health maintenance, rehabilitation, and marked improvements in our environment have grown since the 1920's. As a result of the era of antibiotics, infant, child, and adult mortality rates stand at a fraction of those that had once been recorded for the geriatric population.

For some 30 years, accidents, cancer and heart disease became the major causes of death in children, with suicide and homicide also important through the young adult years. Attitudes have changed. Rather than fear death from most illnesses, persons question either their inopportune presence, or absence of preventives. We do not eliminate defective infants as did the Spartans. We strive toward maximum development of innate ability, no matter how small. The present goal of our total society is contained in the last four lines of a familiar poem written by a famous physician, "The Deacon's Masterpiece," by Dr. Oliver Wendell Holmes. It was concerned with the construction of a "One Hoss Shay" that

would last 100 years. On that one hundredth anniversary:

"... You see, of course, if you're
 not a dunce
 How it went to pieces all at once
 All at once, and nothing first,
 Just as bubbles do when
 they burst."

Longevity without happiness is existence, not living. This becomes ever more important as the geriatric segment of our population will increase in numbers and come to contain a significant proportion alive because of community health agencies, institutions, and especially professions with continually broadening programs of both preventive medicine and health maintenance. How to ensure both is not an exercise in philosophy. It is predicated upon a change in our society's attitude toward aging and its aged, and the practical politics of socioeconomics whereby those of the present and the future can be both wanted and useful to the end. ◀

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IMPAC

ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

I would like to take this opportunity to briefly discuss how we may best help the candidates of our choice in this "off" year. As you know, IMPAC makes contributions to candidates prior to election day. It is important to remember, however, that candidates raise funds in "off" years also. The fundraisers are normally held to either eliminate campaign deficits or provide fresh funds for the candidates next campaign. If you are aware of a fundraiser being held for an officeholder you believe to be a friend of medicine, please let IMPAC know. We are always willing to help our friends. In addition, it is important that you attend these activities to represent yourself, as well as your profession. Your legislator will appreciate your taking the time to see him.

Secondly, meet with the legislators from your district and discuss the issues that are important to you and medicine. The most frequent complaint of legislators is that they only hear from physicians when a "medical" vote is coming up, or when their physician feels they voted incorrectly on a proposal. The State legislature is recessed until October 24th. Take this opportunity to meet with your legislator, discuss medical issues, and ask how you might help him or her as a legislator or a candidate.

Perhaps your legislator would like to meet with you, other members of the medical community and your friends. This does not have to be a fundraiser, but it enables you to act as the key in promoting greater contact between your legislator and his or her constituents.

Finally, if you are not satisfied with your representative or find your representative plans to retire, try to find candidates who will best represent you. Unless the date for the next Primary is changed, candidates for the 1978 election will have to file by December 19, 1977. There is not much time and good candidates are hard to find. It is important to start looking now. The best place to look for a candidate might be in the mirror! How about you ... your spouse ... or a partner as a candidate? Medicine needs better representation in the legislature, and, who can represent us better than a physician or physician spouse?

However you choose to become involved, IMPAC is always willing to help those interested in good government. Please let us know if we may be of any assistance to you.

Pam Taylor

Mrs. Pam Taylor
Chairman

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Copies of IMPAC & AMPAC reports are filed with the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 S. Spring St., Springfield, Illinois, 62704

Drug Abuse Rehabilitation Treatment For Convicted Felons

By H. C. MEYER, M.D., M. ADERMAN, Ph.D., F. SEAMAN, Ph.D.,
R. CHAMBERLIN, M.A., AND N. SOLHKHAH, Ph.D./
CHICAGO AND PHILADELPHIA

It is difficult to obtain an accurate estimate of the number of sentenced, returned or re-committed addict-offenders within the Illinois adult prison system. In 1970, there were 202 new admissions for narcotic offenses;¹ in 1971 there were 255 admissions for narcotic offenses.² A 1971 analysis of the Illinois adult penal system by

type of offense reveals that 7.8%, or 550 men, were incarcerated for narcotic offenses.³ However, it is known that the percentage of prisoners convicted of narcotic offenses represents only a small proportion of addict-offenders in the Illinois prison system. Records obtained from the Stateville Correctional Center suggest that a minimum of 20% of the prison population reveals drug addiction in their histories. Projecting these data to the entire Illinois adult penal system, there could be 1,500 prisoners with drug addiction histories. Further, perhaps 600 prisoners (with known drug addiction histories) are either being paroled or discharged from Illinois' penitentiaries each year. It can be postulated that these projections may indeed be conservative estimates.

It is interesting to note that 73% of the heroin addicts reporting to the Illinois Drug Abuse Program have indicated that they resorted to crime in order to support their habit.⁴ Clearly, drug addiction costs Illinois' taxpayers millions of dollars each year. The epidemic of heroin addiction is placing an increasing financial drain on the taxpayer in terms of dollar loss from crime and increasing crime rates, as well as a need to increase manpower and funds for police services, jails, prisons, courts and welfare costs for the displaced families of addict-offenders. And, most importantly, the waste of human life and potential is enormous.

Description of the Program

The Drug Abuse Rehabilitation Treatment (DART) program began as a demonstration

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project in the Illinois Department of Corrections on January 1, 1971, funded by the LEAA (Grant #71-DF-504) and matching State appropriations. This program was designed to provide a long range psycho-medico-social treatment continuum for former hard core narcotic addicts (all of whom had been detoxified—"cold turkey"—at least one year prior to admission into the program) incarcerated in the State penitentiary system. It provided the clinical arm for the target population as the addict felon progressed from incarceration to parole in three distinct phases. The thrust was to break the vicious crime cycle of the addict felon. The effectiveness of these rehabilitative efforts, it was felt, could be measured adequately only in terms of the individual's ability to adjust to and be continuously employed in the occupational sphere. The felon had to become a regular taxpayer rather than a liability on the taxpaying public. For the most part, it was felt, this could be accomplished only if the external structure was gradually removed as mechanisms for meeting dependency needs were changed and the building of more adequate ego-strength was increased. The three phases of DART were conceptualized to provide a continuum from a maximum of external control and structure to a minimum of external control and structure over a three to four year period.

Phase I:

This phase consisted of an orientation—therapy group which met at the penitentiary on a weekly basis. Applicants were required to meet all statutory and administrative regulations governing admission into work release. These therapy groups were conducted by an experienced clinical psychologist. An innovation which DART engineered in the selection of prisoners for progression from Phase I to Phase II was the active participation by inmates in the selection process. By incorporating this management by participation procedure, given inmates carried some responsibility for the success of the program. Each man's future was, in part, determined by the soundness of the judgments he made about his peers. An average of six months active participation in group therapy preceded the prisoner's progression into the next phase. The decision to advance was based on interviews, peer evaluation and clinical judgment.

Phase II:

This phase consisted of a community-based work center in which the prisoner was incarcerated. Upon arrival, each inmate was examined

(and thereafter treated) by the program physician. The physician reviewed the medical records and evaluated each inmate's drug history. Urine specimens were collected on a daily basis. Staff psychologists provided individual, group and family therapy. Security controls permitted the inmates to leave the site only when accompanied by a staff counselor, excepting transportation to and from work or furlough periods. Additionally, prisoners were administered a battery of objective and projective psychometric measures in order to determine personality or emotional traits which might be distinctive of this population. These measures were, of course, valuable clinical tools for predicting psychic problems and assessing therapeutic progress.

TABLE 1
Criminal Profile of DART Participants

Age	Mean: 34.9 years Range: 22 years-55 years
Number of years addicted to narcotics	Mean: 14.6 years Range: 1 year-25 years
Number of separate incarcerations per prisoner*	Mean: 6.01 incarcerations Range: 1 incarceration-29 incarcerations
Number of felony convictions per prisoner*	Mean: 14.07 convictions Range: 1 conviction-37 convictions
Number of years in prison per prisoner (all convictions)	Mean: 9.3 years Range: 1.8 years-24.3 years
Number of years in prison for present conviction	Mean: 3.1 years Range: 1 year-8.1 years
Number of years in prison per incarceration	Mean: 1.5 years Range: 12 days-10 years

*Because multiple convictions can result in concurrent sentences, it is necessary to distinguish between number of felony convictions and number of separate incarcerations, which are neither concurrent nor consecutive.

Phase III:

After parole, and as its precondition, the released prisoner or parolee was seen on an outpatient basis on a weekly or twice-weekly schedule by the staff physician and staff psychologists. Urine samples were collected on every visit to the work release center. In fact, failure to provide urine samples after parole was considered a parole violation.

Results

Criminal history:

An examination of individual criminal records indicates that there are common characteristics in the criminal records of our treatment population. It is apparent, also, that the use of heroin almost invariably precedes the first felony conviction by at least one year. The maintenance of a heroin habit has encumbered our program participants, on the average, about \$150 to \$300 per day. **Further, the target population evidences, for the most part, a history of "crimes against property" rather than "crimes of violence against persons."** The only reasonable deduction which can be made is that crimes committed by these individuals are related directly to the maintenance of their heroin habit.

Characteristics relative to drug history and criminality have been investigated in some detail, and are presented in Table 1.

Insofar as other investigators have reported that the incidence of opiate addiction is higher in low-income minority groups, descriptive data regarding ethnic background of the DART population are also presented. It should be noted, however, that between 1973 and 1975 the demographic characteristics of our population began to change. It is quite obvious (and, indeed, is a matter of common knowledge) that the use of opiates and their derivatives has spread from "ghetto" areas into middle class suburban areas—and even into the most privileged areas.

In order to articulate the difference between

TABLE 2	
Ethnic Background	
Afro-American	N = 128 % = 77.1%
Spanish (Latin) American	N = 19 % = 11.45%
Anglo-American	N = 19 % = 11.45%

the DART population and that of other Illinois Department of Corrections' work release centers, a comparison is presented on four parameters between the prisoners admitted into the DART program and the prisoners admitted into two other work release programs (for non-addict felons). It should be emphasized that 67% of the crimes committed by prisoners admitted into work release programs for non-addict felons were violent crimes (including

TABLE 3
Comparison of Means

Age	
DART	34.90
Work Release Center I	29.40
Work Release Center II	31.58
Number of separate incarcerations per prisoner	
DART	6.01
Work Release Center I	1.90
Work Release Center II	1.86
Number of years in prison (all convictions) per prisoner	
DART	9.30
Work Release Center I	3.90*
Work Release Center II	5.10*
Number of years in prison for present conviction	
DART	3.10
Work Release Center I	2.40*
Work Release Center II	4.53*

*These means are skewed because several individuals convicted of murder were admitted into this program. The minimum mandatory sentence on conviction for murder is 14 years in Illinois.

murder, attempted murder, voluntary and involuntary manslaughter, rape, attempted rape, cruelty to child, aggravated battery, intimidation, arson, armed robbery, and unlawful possession of a weapon); while only 31% of the crimes committed by prisoners admitted into DART were violent crimes (including armed robbery, unlawful possession of a weapon and aggravated battery).

Medical Findings:

Numerous investigators have demonstrated that psychological stress affects those bodily functions controlled by the autonomic nervous system. Effective balance among many related systems seems to be essential for normal functioning. Acute anxiety reactions represent a disastrous loss of balance in homeostasis.

Under the stress of the program, latent psychosomatic problems become manifest. **It has long been recognized that heroin addicts tend to somaticize anxiety reactions.** The large number of prisoners with duodenal ulcer apparently results from chronic anxiety and stress. Its appearance is probably consistent with the stress applied to the individual while in the program. Therefore, a balance between the degree of stress applied in therapy and the "physiological reserve" of the individual must be achieved. It should be noted that psychotherapy deals with the efficacy of the coping mechanism manifested by individuals dealing with anxieties and perceived stress situations. While psychotherapy and counselling are important, an initial medical history and physical examination are essential

in order to properly diagnose and treat medical problems. Failure to treat the medical problem renders psychotherapeutic intervention impotent, if not impossible. To the best of our knowledge, no systematic efforts have been made to examine, diagnose and treat psychosomatic disorders existing in an opiate treatment population. The reported high failure rate in many programs may be, in part, a function of this inadequacy. It should be noted that the street addict assiduously avoids adequate medical treatment. Only when his situation becomes desperate does he present himself for immediate relief of acute symptoms; and he is rarely seen thereafter.

While each prisoner was given a physical examination and a detailed history was taken on admission into the work release phase, we were presented with problems difficult to surmount. We found that prison medical records were entirely inadequate; and, further, that those received were often inconsistent with actual physical examination. The prisoners' physical and emotional status had not been adequately diagnosed. Although prisoners were admitted into the work release phase only if in "Class A" medical condition, we found that about 80% of our treatment population had not been adequately diagnosed and/or treated. On admission into work release we found several prisoners with frank inguinal hernia, essential hypertension, frank congestive heart failure and complaints of gastrointestinal disorders. Needless to say, several prisoners required hospitalization short after admission into the work release phase of the program.

Psychiatric Profile:

Rather than detail results of the psychometric test data (e.g., "MMPI," "Individual Need Inventory," "Draw A Person," "Taylor Manifest Anxiety Scale," etc.) and the various statistical analyses to which these data were subjected, we have chosen to present a psychiatric profile of the typical DART participant based on these data as well as our clinical observations and impressions.*

Although individual differences exist among DART participants, the mean scores on the various personality attributes do reveal a fairly consistent profile of characteristics. These obtained response tendencies show that the DART members, in contradistinction to the general population, have a greater number of internalized conflicts. For example, they are generally

more cautious, yet they are prone more frequently to behave in an impulsive manner. Further, they indicate a greater degree of detachment from others, while concomitantly evidencing a greater need to rely on others, especially when confronted with a problem. They are at once more deferent and defiant toward authority figures. Moreover, the participants are predisposed to favor a highly structured environmental setting, yet recoil from routinized activities.

It is of particular interest to note their lower frustration tolerance level than a normative group. They also tend to be quite defensive, primarily utilizing the mechanisms of projection and rationalization. To some degree, the DART participants tend to be more achievement oriented than a normative group yet they do not possess the psychic equipment to realize (in a socially acceptable fashion) realistic goals. Psychologically they depreciate self worth where somewhat elevated autonomous strivings

TABLE 4
Diagnosed Psychophysiologic Diseases

Diagnosed disorder*	N
Psychophysiologic skin disorder	N = 3
Psychophysiologic musculoskeletal disorder	N = 74
Psychophysiologic respiratory disorder	N = 6
Psychophysiologic cardiovascular disorder	N = 34
Psychophysiologic gastrointestinal disorder	N = 59
Psychophysiologic genito-urinary disorder	N = 12

*Total number of program participants = 166. Several individuals were diagnosed as having more than one psychophysiologic disorder.

are generally expressed negatively as defiance. Yet, paradoxically, when attempting to realize a socially approved goal an effort is made to "put on a show" for authority figures. Failure results in rationalization and projection in order to preserve ego-integrity.

Additionally, although they demonstrate manipulative behavior when their security is threatened, they favor more of a "live and let live" attitude than do controls under relatively "normal" conditions. In line with this aspect of their temperamental dispositions, they also show a preference for relating to others in a non-punitive way. And although they are less disposed toward going out of their way to be helpful to others or furnishing assistance, their overall demeanor reveals a preference for behaving in a rather "low profile" fashion. That is, the average

* A summary of test results and all subsequent statistical analyses will be made available on request.

DART participant would rather "fit in" than "stand out."

Developmentally, dependency needs are generally not expressed nor met appropriately. Indeed, from a Freudian viewpoint, intravenous injection of a substance from which pleasure is reportedly derived could be viewed as fixation at the oral-incorporative stage. Impulse control is lacking; momentary impulse gratification is paramount with delay resulting in disproportionate

drug. No reinforcer which a correctional system could offer can equal or negate the positive valence provided in the addict's system of reinforcement. At times it has seemed to staff, in efforts to cope with this system of reinforcement, that their attitude is: "if God had made anything better than heroin He hasn't notified us."

Outcome Data:

The following criteria were utilized in determining the components of the overall success of our efforts.

(1) Program participants had to remain free of the use of any illicit drug. This criterion was measured by daily urinalysis. Failure to remain drug-free resulted in automatic return to the penitentiary.

(2) Program participants had to remain crime-free. This was measured in terms of criminal conviction after admission into the program.

(3) Absence without permission while in work release, or absence without leave while on parole status was—because of the serious nature of the violation—considered evidence of failure.

(4) Escape while on work release status was considered as *prima facie* evidence of failure.

(5) Inadequate adjustment while on work release with resultant return to the penitentiary was considered evidence of failure. Further, after parole, violation of the parole agreement resulting in return to the penitentiary was construed as evidence of failure.

(6) Because work and, thus, self-support is a basic requirement for an individual's integration into the mainstream of society, participants had to be employed or actively seeking employment.

Table 5 summarizes the overall success of the DART program.

Conclusions

In 1974, former Gov. Walker appointed an Advisory Board on Work Release and Furloughs. On September 13, 1974, that Board met in order to review the entire work release program. As a result of that meeting, the Advisory Board recommended a five year follow-up study. To the best of our knowledge, this recommendation to the governor has never been implemented. (Previously, staff had recommended to the responsible departmental administrators that a matched control, five year follow-up study be undertaken in order to assess the efficacy of the DART program as well as the entire work release program.)

There is a marked difference in the criminal

TABLE 5

Number of Program Participants Who Have Violated the Various Criterion Categories

Criterion	N
Use of illicit drugs	7
Death from overdose	2
Abuse of alcohol	2
Conviction for crime	12
Absence without permission or	
Absence without leave	8
Escape	10*
Lack of adequate adjustment	8†
Failure to seek employment	1
TOTAL POPULATION IN PROGRAM	
(to date)	N = 166‡
Number of failures	N = 50
Success Rate	% = 69.9

*All escapees were apprehended within four weeks after escape.

†Sixteen (16) participants have been returned to Phase I (DART penitentiary-based therapy groups). Of these, eight (8) have continued participation, been paroled, and continue to lead crime-free and drug-free lives.

‡Of the total population, two (2) have died of natural causes, and two (2) have had their convictions reversed on appeal.

frustration. There is evidence that Oedipal conflicts have never been—even incompletely—resolved. And these basic unresolved conflicts are "papered over" with a bravado bordering on a "Don Juan" ego defense mechanism.

It is clinically most impressive that after introduction to drug and criminal subcultures the basic reward or reinforcement system of our society is replaced by a system of reinforcement best exemplified in "Lord of the Flies." Money and drugs become the sole avenues to power, recognition and peer approval. This system of reinforcement becomes so entrenched that it is difficult to extinguish. Years after detoxification, for example, many men in our population report vivid and pleasurable dreams about heroin, the ritual of preparing the heroin and the adventures—usually criminal—leading to procurement of the

histories of addict felons and non-addict felons. Clearly, for the addict felon, addiction precedes felony conviction. Addicts resort to crime in order to maintain a habit. Further, addicts tend to commit "property" crimes; while non-addict felons tend to commit "violent" crimes.

The high incidence of psychophysiologic disorder has not, to the best of our knowledge, been systematically documented elsewhere. Based on our experience and data, it is concluded that failure to diagnose and properly treat these diseases will almost inevitably lead to relapse. To a large extent, psychosomatic disorders can be traced to childhood patterns of adjustment—or, more appropriately, maladjustment. It is quite possible that individuals with this disorder (either sub-clinical or pre-morbid) are more likely to develop an addiction if this psychosomatic disease is coupled with the constellation of emotional or personality factors previously discussed.

The personality profiles of the addict felons differ from those of a normal population in several important respects. Whether this is the result or one of the causes of opiate addiction is difficult to gauge, because intervention and/or treatment is always after the fact. Conservatively, though, we must espouse the conclusion that emotional conflict and subsequent lack of adjustment and psychic development are, indeed, predisposing factors giving rise to addiction.

It is reasonable to conclude that medical, psychiatric and psychological intervention over a minimum of four years is generally necessary for the "hard core" addict in order to avoid relapse. Without this support, a marked and dramatic relapse and recidivism rate will probably be seen over time. Within a corrections system the medical, psychiatric and psychological services are generally not available to the addict felon. Further, because professional correctional personnel have had little, if any, training in health care services, what appear to us to be obvious "warning signs" requiring intervention are generally ignored until relapse is a *fait accompli*. There appears to be (at least in the population with which we had been working) a well defined "opiate relapse syndrome" which can be averted if intervention is timely.

Evidence, though tentative, is beginning to accumulate which shows that the impressive success rate reported here is only a temporary phenomenon; the relapse and recidivism rates are increasing. It is quite possible that if a matched control, five year follow-up study were undertaken there would be no significant dif-

ference between treatment and non-treatment populations for a number of reasons. (1) The disease of opiate addiction is multi-faceted involving interlocking medical, psychiatric and developmental factors which, in frank addiction, are nested within drug and criminal sub-cultures. Correctional systems cannot treat what is essentially, at its roots, a medical-psychological disease. Without treatment the probability of relapse and recidivism approaches certainty. (2) Treatment must be provided by highly qualified medical and mental health practitioners. "Treatment" provided by professional correctional personnel is not only contraindicated but is often harmful. (3) The massive intervention and treatment provided this target population will have little impact, in the long run, because this intervention and treatment was arbitrarily discontinued after three and one-half years. It is obvious that for this population, treatment would have to be, if effective, a continuing process. (4) Because opiate addiction has been criminalized, the addict has developed a reinforcement system closely linking addiction and criminal behavior. For example, every individual within our population (even if not frankly addicted at the time) has participated in the traffic in illegal drugs and has earned substantial profit. Only if addiction is decriminalized can the reinforcement system linking addiction and criminal behavior be broken. And only, we feel, if the addict does not find reinforcement in engaging in criminal behavior is he amenable to treatment.

We would tentatively propose that the felon—irrespective of his addiction—be subject to full legal penalty. Only after release from incarceration (and only after serving the legal sentence imposed by the court) should he be treated for his addiction by highly qualified medical and mental health care professionals; and this treatment should be mandatory and continuous. ◀

References

1. Illinois Department of Corrections, Division of Research and Long Range Planning: "New Admissions from Court to the Illinois Adult Prison System," December, 1970.
2. Illinois Department of Corrections, Division of Research and Long Range Planning: "New Admissions from Courts to the Illinois Adult Prison System," December, 1971.
3. Illinois Department of Corrections, Division of Research and Long Range Planning: "Population Analysis of the Illinois Adult Prison System," December 31, 1971.
4. Personal communications, diMenza, S., Director of Clinical Evaluation, Illinois Drug Abuse Program.



report

Illinois Society
American Association of Medical Assistants

STAYING ON TOP

BY MRS. JUDITH ANN MILLER, CMA-AC

Instructor, Medical Assistant Program, Triton College, River Grove, Illinois

A continuing reaffirmation of a commitment to educational purposes is evidenced by the program plans, in which Continuing Education Unit (C.E.U.'s) will be awarded, by the Illinois Society American Association of Medical Assistants (AAMA). Medical assistants committed to ongoing education and updated knowledge will find the planned activities expressly suited to their purposes.

As of June, 1977, the AAMA has issued guidelines for medical assistants who have already attained their certification to continue to meet at least minimum continuing education standards. The Education Committee of the Illinois Society, AAMA, is planning relevant program presentations toward satisfaction of these current standards.

MEDICAL ASSISTANTS, who work in physician's offices and clinics, will have access to an introductory assessment session designed to encourage non-certified medical assistants to register for the proficiency examination—the CERTIFIED MEDICAL ASSISTANT (CMA). The basic examination tests five categories of knowledge fundamental to the ambulatory care duties of a medical assistant in an office or clinic setting. Candidates for the CMA exam may elect to sit for additional specialty exams in the Administrative, Clinical or Pediatric categories. Information and registration materials may be ordered from the AAMA Executive Office, One East Wacker Drive, Chicago, IL 60601. Applications for the examination must be completed and re-

turned to the Executive Offices by January 1, 1978.

An "In Service" workshop planned by the Education Committee of the Illinois Society in early 1978 is designed to introduce the CMA exam candidate to the types of questions contained on the examination with a shortened sample exam. Participants will then have their exams scored confidentially and areas of strengths and weaknesses identified. Leaders of the workshop will help candidates plan their study schedules, and help them to develop effective study habits. Books and literature covering all phases of medical assisting and related areas will be available for perusal by the attendees.

This article has concentrated on perhaps the most important benefits of membership in the professional organization for medical assistants, the AAMA: education and continuing education. There are many additional benefits of membership, including subscriptions to professional medical assistant journals, opportunities for group insurance rates, extremely reasonable medical professional liability insurance, and many more. Many physicians encourage their office staff to attend monthly educational programs and to take part in the many rewards of belonging to a professional organization, whose members all work in the same or similar capacities in the medical office or clinic. Each component chapter, state society and national level organization (tri-level) to which a member may belong is wholeheartedly supported by physician-advisors.

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

ARCOLA: F.P. or G.P. needed to join only physician in true rural community (2,300 population). Must be willing to do O.B. Ultimate plans for new 3-man clinic. Close to beautiful county hospital less than 10 years old. Robert N. Arrol, M.D., 126 S. Locust, Arcola, Illinois 61910. (217) 268-4444 or (217) 268-4404. (10)

BEMENT: Population around 1800. Take over established practice of 30 years. Complete office facilities. Financial assistance available. New nursing home. New hospital and nursing home 7 miles. Located 25 miles from Decatur, 30 miles from Champaign hospitals. Choice of newly decorated home city or country. Contact: Mayor J. E. Hargrave, 633 E. Bodman, Bement, 217-678-8186 or Dr. Wm. Scott, 107 E. Bodman, Bement, 217-678-5151. (9)

CHICAGO (desirable suburb): Older general practitioner has excellent office facilities to share with younger G.P. Objective: need help with practice. Younger man may have guarantee to take over practice in near future. Hospital staff appointment available. All replies confidential. Box MK, Physician Recruitment Program, ISMS. (9)

CHICAGO: Take over large general practice. No investment required. Modern fully equipped and staffed facility. Salary and profit sharing. Contact: Jack Pardee, Suite 300, 2400 E. Devon, Des Plaines 60018. 312-298-3500. (9)

CHICAGO: Medical Center with complete facilities needs physician full time for welfare practice. Part time hours are also available. Above average earnings obtainable. Contact: Mohawk Medical Center, 832 West Madison Street, Chicago, Illinois 60607. (312) 421-2199. (9)

CHICAGO: Beautifully furnished and equipped medical suite in brand new medical clinic, with lab and ECG, available now in busy commercial area for GP, Ob-Gyn or Ped. 1620 W. Belmont, Chicago 60657. 935-8900. Mr. Cabreira. (10)

CHICAGO: Medical center position available. Top income to practitioner. Complete facility including X-ray and Lab. Contact: David Sternsheim, 3138 W. Cernak Rd., Chicago 60623 (312-277-4505). (12)

DOLTON: Internist, board certified, full time; Chicago suburban group with complete diagnostic facilities. Excellent starting compensation; profit sharing and pension program. Pleasant working conditions; capable, interested medical associates. Convenient location, regular hours; good hospital affiliations, vacations, insurance benefits include Life, Hospitalization, Catastrophic Medical Expense, Disability for Illness, Accident and Malpractice. Medical society and hospital dues paid by corporation. Call collect: Eugene J. Scherba, M.D. or Administrator, Thomsen Clinic, Ltd., 13826 Lincoln, Dolton 60419, 312-849-2400. (10)

GENESEO: Physicians wanted for Family Practice, OB-Gyn, Pediatrics, Internal Medicine, General and Orthopedic Surgery. Attractive, prosperous, residential community of over 7,000; serving trade area of 35,000 population. Located on Interstate 80, 2½ hours from Chicago; 25 miles east of Quad Cities metropolitan area of 350,000. Ideal, safe, small city living with excellent recreational facilities. New ultra modern hospital with 110 beds. New modern doctor's offices and housing on hospital property immediately available. Attractive financial arrangements include guarantee. Contact Physician Recruitment Committee, 210 W. Elk St., Geneseo, 61254 or phone collect; G. L. Wissink, Administrator (309) 944-6431. (10)

HINSDALE: Seeking physicians for church-related, fee-for-service, family health centers in Chicago western suburbs. Competitive salary, facilities, equipment, malpractice insurance included. Continuing education, patient education, counseling staff, teaching of medical students and residents. Contact Bill Peterson, Pastoral Director, Wholistic Health Center, 137 S. Garfield, Hinsdale, 60521. Phone (312) 986-5252. (9)

KEOKUK, IOWA: Progressive industrial community of 15,000 with 40,000 service area. Opportunities for family practice and internal medicine, solo or group practice. Complete office facilities, financial guarantee and assistance available. Located on Mighty Mississippi. Contact: Dr. Lynn L. Walker, Keokuk Area Hospital, P.O. Box 1500, Keokuk, Iowa 52632. AC 319-524-7150. (9)

LaSALLE-PERU: Board certified or eligible anesthesiologists to head department in North-Central Illinois

hospital serving 35,000 area population. Four CRNA's currently on staff. Located two hours from Chicago, this area offers recreational facilities, good schools and housing. Contact W. T. Schweickert, Administrator, 925 West St., Peru, 61354. 815-223-3300. (10)

LIBERTYVILLE: Family practice physician, G.P. or internist to join new outpatient clinic consisting of full auxiliary facilities, special procedure rooms and future outpatient surgical center. Located in a rapidly growing area near lakes, shopping centers, recreation areas and easy access to Chicago theaters, museums and cultural events. For information call 312-362-0020, write Dr. G. Gaverty, 611 S. Milwaukee, Libertyville, 60048. (9)

MACOMB: Western Illinois University—Seeking Director University Health Service. Present enrollment 14,000. Director is Chief Administrative Health Officer supervising nursing and para-medical staff in modern health facility. Forty-hour work week; paid vacation; sick leave; hospitalization insurance; excellent retirement program. Contact V.P. Student Affairs, Western Illinois University, Macomb 61455. An Equal Opportunity Employer. Phone 309-298-1814. (10)

MURPHYSBORO: Board certified or eligible, one pediatrician, one surgeon; to join a solo OBS-GYN in a progressive community hospital. Enjoy golf, deer hunting, fishing, water sports in beautiful pollution free area. Guaranteed income, excellent fringe benefits with progressive increases and partnership in three years. Interested applicants contact: U. Matias, M.D. 618-687-1901 home, 618-687-3351 office. (10)

PEORIA: Immediate full time position open for career minded physician in progressive 550 bed hospital. Opportunity to practice Emergency Medicine in busy emergency department seeing 26,000 visits as well as teach medical students and Family Practice residents. Work 16 or 24 hour shifts with excellent specialty back up. Compensation above average with flexible scheduling. Enjoy a dynamic, friendly community of 250,000 in central Illinois. Forward curriculum vitae or contact H. Stratton, M.D., 221 N.E. Glen Oak, Peoria 61636, at 309-672-5500 or 309-691-7410. (10)

ROCKFORD: 250-bed hospital-Regional Trauma Center seeks Emergency Room Physician interested in EMS programs. New paramedic program; affiliated with Rockford School of Medicine. New emergency room facilities include x-ray capabilities; state-wide radio network; Poison Control Center; heliport. Second largest city in Illinois, located one hour west of Chicago and close to Wisconsin resort areas. Contact: Bob Flodin, St. Anthony Hospital Medical Center, 5666 East State Street, Rockford, 61101 (815) 226-2010. (10)

SULLIVAN: A new \$1,000,000 medical facility is looking for doctors in a midstate town of 4,000. It offers challenging positions for creative individuals to design and implement patient-care programs. Partnerships with established doctors also available. Three hospitals are within thirty miles. An 11,000 acre recreational lake is nearby. Contact: Bob Lemler, 200 S. Hamilton, Sullivan, 61951. 217-728-4311. (10)

TUSCOLA: Internist needed, Excellent hospital facilities. Located twenty miles from Champaign-Urbana

and the University of Illinois campus. Financial assistance, office facilities available. Contact Norm Rentz, 704 N. Main St., Tuscola, 61953. (217) 253-3361. (10)

WASHINGTON: Population over 10,000. Physician recently moved to Florida. Three physicians at present. Eleven miles from Peoria's three hospitals and Peoria Medical School. Some financial aid available. Excellent schools, parks, etc. Contact: Dean R. Essig, 135 Washington Square, Washington, 61571. (309) 283-8041. (9)

WHITE HALL: Area population 12,000. Family Practitioners, Internist and Pediatrician needed. 30 bed hospital, expansion in process. 2 Physicians. Excellent schools, recreation and housing. Contact Larry Bear, White Hall Hospital, White Hall 62092. (217) 374-2121. (10)

EKG

(Continued from page 109)

Answers: 1. C 2. C,D,E

The three lead simultaneous rhythm strip shows atrial tachycardia with 2:1 atrioventricular block. The inverted P waves can be seen best in lead III (bottom strip) at a rate of 200/minute. The P wave axis here is approximately -90° suggesting the focus is not near the sinus node. The ventricular response is 100/minute. Atrial tachycardia with AV block is a very common arrhythmia in digitalis intoxication. However, the atrial rate is often slower than 200/minute and other complaints of digitalis excess are often present. This lady had a serum Digoxin level of 1.8 ng/ml and no symptoms of excess digitalis. Bed rest, low Sodium diet and 40 mg. of Furosemide allowed loss of edema over several days. The same dose of Digoxin was maintained since it was in the therapeutic range. The atrial tachycardia spontaneously converted to sinus rhythm after three days in the hospital. Her prosthetic mitral valve was shown to be functioning well by fluoroscopy and echocardiography. Although this is a common arrhythmia in digitalis intoxication, it can be seen in diseased hearts as well. In this patient moderate dietary sodium restriction, diuretic therapy, and maintenance Digoxin allowed control of her congestive heart failure and a return to sinus rhythm.

ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110



Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

SEPTEMBER

Cardiology

For: Physicians. Lecture, September 14, 1977, 9:00-5:00 PM, 950 E. 59th Street, Chicago, IL. **CME Credit:** 6 hrs. **AMA Category 1:** 6 hrs. **AAPF Elective:** Fee: \$30.00. **Sponsor:** University of Chicago, Frontiers of Medicine, 950 E. 59th Street, Chgo., IL. 60637, Box 451. **Contact:** Elaine Ehrman, Secretary. Telephone: (312) 947-5777.

Cardiovascular Diseases

CARDIOLOGY: DRUG THERAPY AND NON-INVASIVE DIAGNOSTIC METHODS
For: Internists, Cardiologists, Family and General Practitioners. September 14 ending November 2, 1977. St. Luke's Hospital East, 5535 Delmar, St. Louis, Missouri 63112. **CME Credit:** 16 hrs. **AMA Category 1 and AAPF Elective:** Fee: None. **Sponsor:** Washington University School of Medicine, Office of Continuing Medical Education, 660 South Euclid Ave., St. Louis, Missouri 63110. **Contact:** Loretta Giacometti, Administrative Coordinator. Telephone: (314) 367-9673. **Co-Sponsor:** St. Luke's Hospital.

Family Medicine

REVIEW AND UPDATE OF SOME COMMON CLINICAL PROBLEMS IN RENAL DISEASE
For: Internists, Osteopaths, Family and General Practitioners. Symposium, September 30, 1977. Tan-Lake of the Ozarks, Missouri. **CME Credit:** 6 hrs. **AMA Category 1 and AAPF Elective:** Fee: \$60.00. **Sponsor:** Washington University School of Medicine, Office of Continuing Medical Education, 660 South Euclid Ave., St. Louis, Missouri 63110. **Contact:** Loretta Giacometti, Administrative Coordinator. Telephone: (314) 367-9673.

Family Therapy

THE THERAPIST'S OWN FAMILY
For: Physicians and Mental Health Practitioners. Ongoing Seminar, September 10, 1977, 9:00-1:00 PM. **Speaker:** Jeanette R. Kramer. **CME Credit:** 20 hrs. **AMA Category 1:** Fee: \$150.00. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron St., Chicago, IL 60611. **Contact:** Belinda M. Stone, Sec. Workshops/Conference. Telephone: (312) 440-1414. **Co-Sponsor:** Institute of Psychiatry, Northwestern Memorial Hospital and Northwestern University Medical School.

Family Therapy

TECHNIQUES FOR WORKING WITH SEVERELY DISTURBED FAMILIES
For: Physicians and Mental Health Practitioners. September 16, 1977, 9:30-4:30 PM. **Speaker:** Froma Walsh, Ph.D., Department of Psychiatry, Michael Reese Hospital. **CME Credit:** 7 hrs. **AMA Category 1:** Fee: \$40.00. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago, IL 60611. **Contact:** Belinda M. Stone, Sec. Workshop and Conferences. Telephone: (312) 440-1414. **Co-Sponsor:** Institute of Psychiatry, Northwestern Memorial Hospital and Northwestern University Medical School.

Internal Medicine

ISSUES OF CERTIFICATION AND RECERTIFICATION
For: All physicians. Banquet, September 10, 1977, 6:30 PM. **Speaker:** Neil Chayet, Attorney at Law, Boston, Mass. **CME Credit:** None. **Fee:** \$15.00. **Sponsor:** Illinois Society of Internal Medicine, 55 E. Monroe, Suite 3510, Chicago, IL. **Contact:** Wendy J. Smith. Telephone: (312) 782-1654. **Co-Sponsor:** American College of Physicians (Illinois region).

Oncology

SPECTRUM ON ONCOLOGY, PART I AND II
For: Physicians, Interns and Residents. 2 Part Lecture, September 7, 1977, Part I on September 21, 1977, Martha Washington Hospital, 4055 N. Western Ave., Chicago, IL. **CME Credit:** 2 hrs. **AMA Category 1 and 2 hrs. AAPF Elective:** Fee: None. **Reg. Limit:** 90. **Reg. Deadline:** September 6, 1977 and September 20, 1977. **Sponsor:** Medical Staff of Martha Washington Hospital, Medical Director's Office, 4055 N. Western Ave., Chgo., IL. **Contact:** Fernando Villa, M.D., Medical Dir., or Rosemary Bradkowski, Executive Medical Secretary. Telephone: (312) 538-9000 ext. 331.

Psychiatry

TRACE ELEMENTS IN PSYCHOSIS
For: Professionals and Students in the Health Field. Lecture, September 7, 1977, 3:00-5:00 PM, Forest Hospital Professional Center, 555 Wilson Ln., Des Plaines, IL. **Speaker:** Carl Pfeiffer, Ph.D., M.D., Dir., Brain Bio Center, Princeton, New Jersey. **CME Credit:** 2 hrs. **AMA Category 1:** Fee: \$15.00 for Professionals; \$10.00 for students. **Reg. Limit:** 100. **Sponsor:** Forest Hospital Foundation. **Contact:** Leo Jacob, M.D., Director of Medical Education. Telephone: (312) 827-8311.

Variety

AMA CHICAGO REGIONAL CME PROGRAM
For: Family Practitioners and General Practitioners. Courses, September 24 and 25, Holiday-Inn, Chicago City Center, Chicago, IL. **CME Credit:** 12 hrs. **AMA Category 1:** Fee: \$70.00. **Sponsor:** American Medical Association and Chicago Medical Society, 535 N. Dearborn St., Chicago, IL. **Contact:** John W. Sturgeon, Program Coordinator. Telephone: (312) 751-6519.

OCTOBER

Anesthesiology

EKG FOR ANESTHESIOLOGISTS
For: Anesthesiologists. Lecture, October 3, 1977-One week. Cook County Graduate School of Medicine. **Speaker:** Alon P. Winnie, M.D. **CME Credit:** AMA Category 1 credit. **Fee:** \$200.00. **Reg. Limit:** 35. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Contact:** Robert J. Baker, M.D., Dean. Telephone: (312) 733-2800.

Asthma

ASTHMA—A DISEASE IN SEARCH OF A PATHOGENESIS: WHO SHOULD TREAT IT AND HOW SHOULD IT BE TREATED
For: GP, FP, IM, Allergists, Chest Surgeons, Peds, etc. Symposium, October 16, 1977, 9:00-5:00 PM, Oak Brook Hyatt House, Oak Brook, IL. **CME Credit:** 6 hrs. **AMA Category 1 and 6 hrs. AAPF Elective:** Fee: None. **Sponsor:** DuPage County Medical Society, 26 West Street, Charles Road, Lombard, IL 60148. **Contact:** Lillian S. Widmer, Executive Secretary. Telephone: (312) 495-4050. **Co-Sponsor:** Geigy Pharmaceuticals.

ADVANCED EKG

For: Internists. Lecture, October 10, 1977—2½ days. Cook County Graduate School, 707 Wood St., Chicago, IL 60612. **Speaker:** Kenneth Rosen, M.D. **CME Credit:** AMA Category 1 credit. **Fee:** \$125.00. **Reg. Limit:** 75. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D. Telephone: (312) 733-2800.

BASIC ELECTROCARDIOGRAPHY

For: Internists and Family Practitioners. Lecture, October 3, 1977—One Week. Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL. **Speaker:** Kenneth Rosen, M.D. **CME Credit:** AMA Category 1. **Fee:** \$200.00. **Reg. Limit:** 50. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D. Telephone: (312) 733-2800.

Dermatology

BASIC DERMATOLOGY
For: Family Practitioners. Lecture, October 10, 1977—One Week. Cook County Graduate School of Medicine, 707 S. Wood St., Chgo., IL. **CME Credit:** AMA Category 1. **Fee:** \$200.00. **Reg. Limit:** 100. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D. Telephone: (312) 733-2800.

Institution recently awarded Continuing Medical Education Accreditation:
Illinois Hospital Association
Oak Brook, IL.

Family Medicine

WORKSHOPS FOR HEALTH PROFESSIONALS
For: Physicians and Nurses. Workshop, October 27-29, 1977, LaCrosse, Wisconsin. **CME Credit:** 15 hrs. **AMA Category 2:** Fee: \$165.00. **Reg. Deadline:** September 15, 1977. **Sponsor:** The Pain and Health Rehabilitation Center, Route 2, Welsh Coulee Road, LaCrosse, Wisconsin 54601. **Contact:** C. Norman Shealy, M.D. Telephone: (608) 786-0611.

Family Therapy

TRANSACTIONAL ANALYSIS AND GESTALT APPROACHES TO FAMILY THERAPY
For: Physicians and Mental Health Practitioners. Two-Day Workshop, October 21 and 22, 1977; 9:30-3:40 PM, 1307 E. 60th St., Chgo., IL. **Speaker:** Les Kadis, M.D. **CME Credit:** 14 hrs. **AMA Category 1:** Fee: \$70.00. **Reg. Limit:** 100. **Sponsor:** Center for Family Studies/The Family Institute of Chicago, Ten Huron Street, Chgo., IL. **Contact:** Belinda Stone. Telephone: (312) 440-1414. **Co-Sponsor:** Institute of Psychiatry, Northwestern Memorial Hospital and Northwestern University Medical School.

Geriatrics

WHAT'S NEW FOR THE OLD
For: Practicing Family Physicians. Seminar, October 7-8, 1977, Mequon Care Center, Mequon, Wisconsin. **CME Credit:** 10 hrs. **AAPF Prescribed and 10 hrs. AMA Category 1:** Fee: \$90.00. **Reg. Deadline:** September 15, 1977 or registration at door. **Sponsor:** Department of Family Practice, The Medical College of WI, c/o Deaconess Hospital, 610 N. 19th St., Milwaukee, Wisconsin. **Contact:** Nancy Sheppard, Administrative Secretary. Telephone: (414) 933-0700. **Co-Sponsor:** The American Geriatrics Society.

Infectious Disease

CUTANEOUS LESIONS IN INFECTIOUS DISEASE
For: Physicians, Interns and Residents. Lecture, October 12, 1977, 11:00-12:00. Robert C. Hartman, Sr. Auditorium. **Speaker:** Charles A. Kallick, M.D. **CME Credit:** 1 hr. **AMA Category 1 and 1 hr. AAPF Elective:** Fee: None. **Reg. Limit:** 80. **Sponsor:** Medical Staff of Martha Washington Hospital, Medical Director's Office, Martha Washington Hospital, 4055 N. Western Ave., Chicago, IL. **Contact:** Fernando Villa, M.D., Medical Director, Chairman, Continuing Medical Education Program. Telephone: (312) 583-9000 ext. 331.

Internal Medicine

STATE AND NATIONAL BOARD REVIEW COURSE, CLINICAL
For: Internists and Family Practitioners. Lecture, October 3, 1977—6 days. Cook County Graduate School of Medicine, 707 S. Wood St., Chgo., IL. **Speaker:** Sheldon S. Waldstein, M.D. **CME Credit:** AMA Category 1 credit. **Fee:** \$250.00. **Reg. Limit:** 150. **Sponsor:** Cook County Graduate School of Medicine. **Contact:** Robert J. Baker, M.D. Telephone: (312) 733-2800.



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REPORT

FOR *Illinois Physicians*

Blue Shield Workshops Scheduled for the Fall

The Illinois Blue Shield Plan will conduct workshops for medical assistants in Cook County during October through mid-November. The series begins October 5 and ends on November 17.

Dates and places for meetings are as follows:

Wed., Oct. 5	Holiday Inn 17100 Halsted	Harvey
Wed., Oct. 12	Sheraton Motor Inn 9333 S. Cicero Avenue	Oak Lawn
Thurs., Oct. 13	Sheraton Motor Inn 9333 S. Cicero Avenue	Oak Lawn
Wed., Oct. 19	Holiday Inn 1501 Sherman	Evanston
Wed., Oct. 26	Howard Johnson 8201 W. Higgins Road	Chicago
Wed., Nov. 2	Arlington Pk. Hilton Euclid & Rohlwing Rd.	Arlington Hts.
Thurs., Nov. 3	McCormick Inn 23rd and the Lake	Chicago
Wed., Nov. 16	Conrad Hilton Hotel 720 S. Michigan Avenue	Chicago
Thurs., Nov. 17	Conrad Hilton Hotel	Chicago

Letters with meeting schedules and reservation forms have been sent to physicians' offices in Cook County inviting medical assistants to attend one of the workshop programs. Reservation forms should be returned as promptly as possible to the Professional Relations Department of Blue Shield. For additional information on the meetings, write or phone Loretta O'Donnell, Professional Relations Department, Blue Cross and Blue Shield, 233 North Michigan Avenue, Chicago, Illinois 60601. Phone (312) 661-2964.

Staff members of the Professional Relations Department will serve as instructors in the workshops. Special classes will be held for experienced medical assistants and for those having less than one year's experience.

Medical assistants planning on attending may register for either a morning or afternoon program. Registration for a morning session begins at 8:30 A.M. The workshops start at 9:00 A.M. and continue to 12:00 noon. The program is repeated at 1:30 P.M. after the luncheon; adjournment is at 4:00 P.M. Those attending either morning or afternoon sessions are invited to the luncheon.

The program will include a slide presentation on the processing and payment of Blue Shield claims; explanation of the Medical Necessity Program; the new Blue Shield Report forms; the Pre-Admission

Testing Program; a review of Reciprocity and suggestions for using the Hotline Service.

The agenda will also include discussion of Medicare coverage and how to speed the payment of claims.

Change in Member Identification

The following accounts now require that members use their employee Social Security number in place of the standard 5-digit subscriber number for identification purposes on claim forms when services are received. Use of the employee Social Security number for identification also applies when services are rendered to dependents.

When submitting a Blue Shield Physician's Service Report form, the necessary sequence for member identification would be the Group Number, followed by the employee Social Security number entered on the top line of the claim form.

Following are the account groups and effective dates of change:

Name	Group Number	Effective Date
Commonwealth Land Title Insurance Co.	43889	June 1, 1977
Loctite Corporation	43892	July 1, 1977
Morse Electro Products Corp.	43877	May 1, 1977
Pacesetter Industries	43876	June 1, 1977
Fasson Division of Avery	43895	July 1, 1977

Co-Care and HMO Members Have New Prefix Identifications

Illinois Blue Cross and Blue Shield members enrolled in Co-Care and Health Maintenance Organization programs will be identified with single Alpha prefix letters S, L, H or C with their group number for membership identification. For example: C1270 would identify a Chicago Board of Education employee enrolled in a Co-Care facility.

When services are furnished to a member enrolled in one of the above programs, please use our regular Blue Shield Physician's Service Report form in filing the claim and enter the Alpha prefix letter plus the group number as it appears on the membership identification card.

After completing the report, send it to Blue Cross and Blue Shield, 233 N. Michigan Ave., Chicago, Illinois 60601 for payment.

Payment for Consulting Services

Payment for consulting services is made by Medicare when such services are determined to be reasonable and necessary to assist the attending or referring physician in assessing the patient's total medical condition.

A consultation is a request from the attending or primary physician for the advice and counsel of an accredited specialist. For payment of services by Medicare, a consulting physician must—on either the SSA-1490 form or his own billing statement—state the diagnosis and give the name and address of the referring or attending physician. A consultation must include a history, examination and written report filed with the patient's permanent medical record maintained by the attending physician.

Levels of Consultations

There are two levels of consultations furnished inpatient Medicare patients: a limited type and a comprehensive consultation.

A limited consultation is an examination and/or evaluation of a single organ system which does not require a comprehensive history.

A comprehensive consultation includes a history and examination; an extensive review of medical records; compilation and assessment of diagnostic material; and the preparation of a report for the attending physician.

Type Should be Indicated

When billing the Part B Medicare carrier for consultations always indicate which type of consultation was performed. If a comprehensive consultation was furnished, the description of services should include a comprehensive history and physical examination, with a written report for the patient's medical record. Without a clear description, the Medicare carrier generally assumes it was the limited type of consultation that was provided.

A referral is not considered a consultation. Referral implies the transfer of a patient to another physician for the management of a specific condition or procedure. In the case of a consultation, the patient most generally is returned to the primary physician. When it is decided that the patient would best be served by having the condition managed by the consulting physician, any continuous reimbursement to both physicians is evaluated on the special circumstances involved. The initial examination would be considered a consultation and is reimbursable if medically necessary and reasonable.

COVERAGE OF ALLERGY TREATMENTS

Payment is made for allergy treatments by Part B Medicare under the following circumstances:

(1) When the allergist prepares and charges the patient for an allergenic extract and he administers the extract.

(2) If the extract is administered by another physician, the cost of the extract is covered only if the administering physician obtains the extract from the allergist and the cost is included in the administering physician's itemized statement to the patient.

(3) When the allergist charges the patient for the extract but another physician administers it, payment is made to the allergist for administering the extract but not for the extract itself.

Billing for Allergy Treatments

Allergists commonly bill separately for the initial diagnostic work and for the course of treatment that follows. When it is necessary for the physician to treat the patient for an extended period, the allergist may bill with one statement for all treatments or on a periodic basis, i.e., monthly or quarterly.

When billing periodically, charges for services are considered *incurred* under the Medicare program *at the time they are actually performed*. Charges for anticipated services are not considered incurred under the program. When billing on a one-statement, flat fee basis, caution must be observed that services were not performed prior to the beginning of a patient's coverage or after his coverage ended.

The SSA 1490 Request for Medicare Payment form should be submitted (1) after the last treatment charged on the billing statement has been given; or (2) when billing for all treatments during a calendar year, at the end of that calendar year.

Coverage of Hydrophilic Soft Contact Lens for Corneal Bandage

Two hydrophilic soft contact lenses for corneal bandages are accepted for payment by Medicare:

(1) The Softcon (Vifilcon A) corneal bandage lens produced by Warner-Lambert Company, and (2) the Softlens (Polymacon) corneal bandage made by Bausch and Lomb, Inc.

Payment may be made for either of the lenses when they are employed to treat the conditions for which they are specially approved. To be covered as a supply "incident to" a physician's service, the lens must have been applied and removed by the physician billing for the lens.

Editorials



A Warning to Physicians (Or the Unexpected Case of Cerebral Embolus)

Doctor Levine submitted this editorial to the IMJ as a warning to fellow physicians. Its poignancy is yet more sharp at this time. Doctor Levine died as a result of the above-captioned disorder in October of last year. Publication has been authorized by Mrs. Levine.

Beware Doctor, it can happen to you. It did to me.

Reduce your work load and shorten your hours. You'll live longer. Take the time to enjoy your family and your home. Don't neglect that annual physical that you have long postponed because you were "too busy."

On November 12, 1975, while attending a post-graduate medical meeting at St. Mary's Hospital in Centralia, I suddenly became very drowsy. I had neither headache, vertigo, nausea or chest pains. It was 3:30 p.m. I left the meeting and drove home. When I arrived ten minutes later, I told my wife that I was very tired and intended to nap. I asked her to awaken me at 6:00 p.m.

I sat in a chair to remove my shoes, momentarily placing both forearms and hands on top of a glass topped desk. Lightning struck without any warning.

My left upper extremity shot up in the air and above the shoulder as though it were a projectile shot from a gun. There was a sudden sensation of numerous red hot irons jabbing at my left arm, forearm and hand (ask your stroke patients about this symptom!)

This continued for ten or fifteen seconds. Then, my entire left upper extremity executed a series of coarse, convulsive spasmodic jerkings for another ten seconds. The extremity became heavy and dropped into my lap. It was paralyzed.

I tried to call my wife, but my tongue became thick and I was unable to speak. My left leg, the last to be affected, became paralyzed at 4:10 p.m. I was in the emergency room of the hospital I had left 40 minutes before.

My speech returned shortly after admission to the hospital. On the following day I was able to move my left leg. On the fifth hospital day I could raise my left arm and bend my elbow, and movement gradually returned to the fingers of my left hand. I received a series of electric stimulations and physical therapy.

The attack had numerous sequela, including weakness in the left wrist and fingers and episodes of numbness and tingling in the left little finger. Convulsive or spasmodic jerkings when fingertips touch a flat surface have also occurred. My reflexes are diminished and I tire easily. I might add that I had had several attacks of coronary heart disease, including cardiac arrest, in the past.

I am fortunate that I shall be able to practice medicine again, part time.

The many arduous hours of work, day and night, and neglected physical checkups have paid poor dividends. So slow down your heavy work schedule and "make every day count." No one has ever seen a Brink's money truck following a funeral cortege into the cemetery.

Herbert J. Levine, M.D.
February 8, 1976

OLBY PROCLAIMS WOMAN SUFFRAGE

signs Certificate of Ratification
at His Home Without
Women Witnesses.

ILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony,
But Both Factions Are

WASHINGTON, Aug. 26, 1920—
of struggle for woman



TRUMAN CLOSES NATIONS CONFERENCE WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great
Instrument of Peace,'
Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing
Ovation as Executive
Pictures Peace Gain

Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,000
Persons When States Adopt Cooperating Laws—He C
the Measure 'Cornerstone' of His Economic Progra

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution
is Sent to House, Where
Passage is Expected

WASHINGTON, March 10,
1971—The Senate approved
today, 94 to 0, and sent to

WASHINGTON, Aug. 14.
The Social Security Bill, pr
a broad program of unempl
insurance and old age pe
and counted upon to benef
20,000,000 persons, became
day when it was signed by
dent Roosevelt in the pres
those chiefly responsible f
ting it through Congress.

Mr. Roosevelt called the r
"the cornerstone in a st
which is being built."
means complete

SIGNING the Draft Ends No

"If we fail to use it," he declared
to the solemn final meeting of the
delegates, 'we shall betray' all of
those who have died in order that
we might meet here in freedom and
safety to create it."

"If we seek to use it selfishly—for
the advantage of any one nation or
any small group of nations—we
shall be equally guilty of that be-
trayal."

Eloquent Interpolation

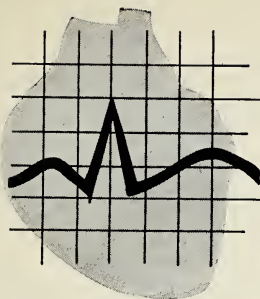
The President, speaking in the
auditorium of the War Memorial
Opera House, built in memory of
sons of the Golden Gate city who
gave their lives in the first World
War, in which he himself served,
seemed to give unconscious expres-
sion to the solemn feeling of the
occasion when, at the outset of his
speech, he interpolated the words,
half a hope, half a prayer.

"Oh, what a great day this can
be in history!"

Just before the plenary session
the President accompanied the

WASHINGTON, Jan. 27,
1973—"With the signing of
the peace agreement in
Paris today, and after re-
ceiving a report from the
Secretary of the Army that

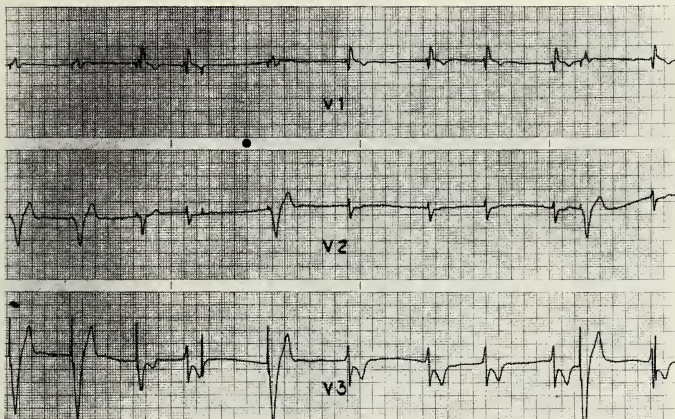




ekg of the month

JOHN F. MORAN, M.S., M.D., DAVID L. FISHMAN, M.D.,
PATRICK J. SCANLON, M.D., SARAH A. JOHNSON, M.D.,
JOHN R. TOBIN, M.S., M.D., AND ROLF M. GUNNAR, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

This is a fifty-four year old man who complained of worsening dyspnea on exertion for several months prior to admission. He had a history of acute rheumatic fever in 1946. On questioning, he stated that he was able to walk one block slowly or climb two flights of stairs. During this period of time he had dieted and lost thirty pounds in weight. This had helped but he still felt limited. Heart examination showed a pulse rate of 54/minute, a few fine crepitant rales in both lung bases, and a grade 3/6 pansystolic apical murmur. A temporary pacemaker was placed in the right ventricle by the transvenous approach. This simultaneous lead V1-V2-V3 rhythm strip was recorded a few hours later.



Questions:

1. The ECG shows.

- A. Atrial fibrillation.
- B. Complete right bundle branch block.
- C. Intermittent failure of the pacemaker.
- D. Short runs of idioventricular rhythm.
- E. All of the above.

2. Which of the following statement(s) are true?

- A. This slow rhythm could be caused by digitalis excess.
- B. A permanent pacemaker should be promptly put in place.
- C. Lidocaine should be given intravenously.
- D. The temporary pacemaker should be examined and repositioned.
- E. All of the above.

(Continued on page 209)

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE **DYAZIDE®**

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES

SENSE

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* Warning

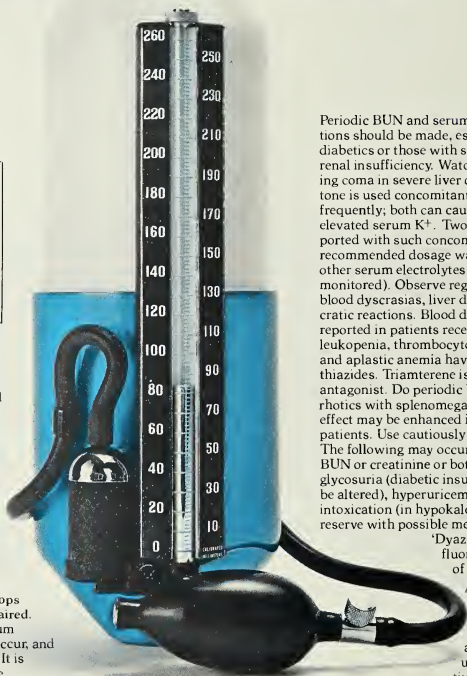
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids).



**FOR LONG-TERM CONTROL
OF HYPERTENSION*
SERUM K^+ AND BUN SHOULD
BE CHECKED PERIODICALLY.
(SEE WARNINGS SECTION.)**

Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spirinolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+ . Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

*Dyazide® interferes with fluorescent measurement of quinidine.

Adverse Reactions:

Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions;

nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

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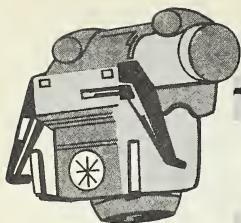
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(number)

4-9



the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

Bilateral Renal Cysts

BY V. L. WILLIAMS, M.D., R. B. DANLEY, M.D., R. J. CHURCHILL, M.D., AND
C. J. REYNES, M.D./MAYWOOD

The patient is a moderately obese 63-year-old male with adult onset diabetes and mild hypertension controlled medically who complains of post prandial RUQ fullness. Masses are questionably felt in the abdomen, but are poorly characterized because of the obesity. Amylase was normal and BUN was minimally elevated. The UGI series shows antero-medial displacement of the second portion of the duodenum. There may be some displacement of a loop of jejunum as well (Figures 1A and 1B). The walls of the abdominal aorta demonstrate calcification. The liver scan demonstrates flattening of the caudal aspect of the liver (Figure 2).

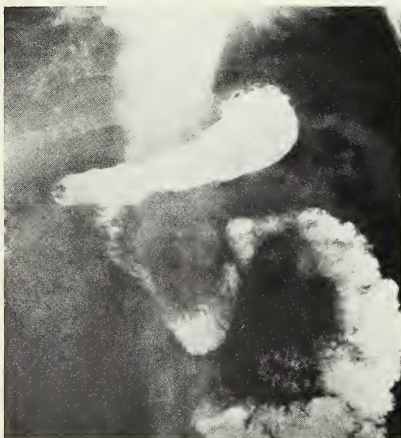


Figure 1A



Figure 1B



Figure 2

What's your diagnosis?

1. Lymphoproliferative disorder
2. Bilateral renal masses
3. Space occupying process in the right lobe of the liver
4. Pseudocyst of the pancreas

(Answers on page 219)

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have time for
personal financial planning.**

The Northern Trust does.

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Bring your future to us.

Danger Ahead: Rationing of Care

In medicine as in other purchases, the buyer gets what he pays for. There is no steak-house medicine at hash-house prices. Prices of care cannot be harshly cut without cutbacks in the quality or quantity of care.

The hard-boiled truths are obvious to us as physicians, who deal with costs as a day-to-day reality rather than a pliable abstraction. And in its somewhat oblique fashion, the federal government seems to perceive those truths, too.

The government's cluster of programs and proposals for containing costs is cosmetized—pure benefit for the patient, without any actual loss on his part. Upon analysis, however, they generally boil down to rationing of care.

This was a central point—and a central danger—posed by Richard E. Palmer, M.D., in addressing the AMA's annual convention last June. Doctor Palmer identified rationing of care as a common denominator. Beneath this umbrella, Dr. Palmer included proposed restraints of so-called unnecessary surgery covered by public funds, HMOs, the Health Planning Act of 1974, the push for generic drugs, and the proposed "cap" on hospital charges as a prelude to the administration's National Health Insurance proposal.

On the proposed ceiling on hospital charges, he asked:

"Is it not predictable that the most creative, resourceful, and conscientious hospitals would suffer from such economic artifice? Or that in

treating all hospitals alike, the cap would penalize those that are already efficient, as a Senate health expert was quoted?"

It also must be recognized that some hospitals lack efficiency, that some communities are overbedded and that costs—the "number one" health care concern of the public—can be restrained without disastrous quality losses. The medical field, through such means as the AMA's Commission on the Cost of Medical Care, must do its practical best against the economics that encourage federal rationing of health services.

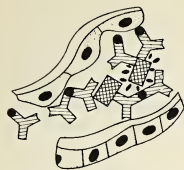
Doctor Palmer noted that HMOs have been hailed on Capitol Hill as "a great piece of ammunition" against rising medical costs. But, he added, what about the amount of care? Recent studies indicate that HMO physicians see their patients less often and give less service—including preventive care—than do fee-for-service physicians.

Shrinkage of service also could be the upshot of any NHI program that would mimick Britain's National Health Service, said Doctor Palmer. It has happened there.

As he summed up: "No individual—and ours is a nation of individuals—wants his care to fall victim to cost-effective common denominators. No individual wants his own care to be rationed."

Physicians at the local level should get this point across—as the government sharpens its ax against necessary costs.

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Seminars In Immunopathology and Oncology

RICHARD J. ABLIN, PH.D., CONTRIBUTING EDITOR

Some Immunologic Aspects of Sarcoidosis

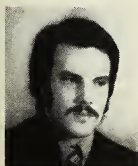
BY MARK MEYERS, M.D./CHICAGO

Sarcoidosis is a disease characterized by granuloma formation accompanied by profound changes in the immune system. Spector¹ has suggested that the lesion in sarcoidosis is a high turnover granuloma indicating a rapid influx and production by mitosis of new cells as old ones are removed. One can only surmise the explanation for this cellular response, which is responsible for granuloma formation. Some insoluble antigen which cannot be removed from the tissues is undoubtedly the offending agent. Known examples of such antigens that cause granuloma formation are the organism *Mycobacterium tuberculosis* and the eggs of the schistosomes. Warren² noted a cell-mediated immune response producing granulomas in the face of generalized delayed hypersensitivity suppression in sarcoidosis patients. The T cell-mediated delayed hypersensitivity arm of the immune sys-

tem shows the most striking changes in sarcoidosis patients. However, there are also aberrations in B cell function, which is concerned with production of antibody. In almost all cases of sarcoidosis, however, humoral immunity is intact.

Approximately two-thirds of patients with sarcoidosis have marked suppression of delayed hypersensitivity. They show little or no reaction to antigens to which most of the population is sensitive (i.e., common fungal antigens, viral antigens, and contact sensitizers like DNCB). Fernandez³ feels the defect is due primarily to a decrease in the number of T cells present in sarcoidosis patients. The number of T cells present is not at the threshold level for *in vivo* manifestation of delayed hypersensitivity. Hedfors⁴ had revealed this evidence earlier and both groups found atypical cells which had no surface markers for either T or B cells and were not phagocytic. These atypical cells may be nonfunctioning T lymphocytes which would contribute further to the decrease in the pool of viable T cells. Sarcoidosis patients in varying clinical stages of the disease showed no significant changes in the numbers of T and B cells.

Sequestration or trapping of T cells may also reduce their effective number in the spleen and peripheral lymph nodes.⁵ There is evidence pointing to a recirculating pool of lymphocytes which travel through the spleen and peripheral lymph system. Most of these recirculating



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lymphocytes are T cells. Granuloma production in the spleen and lymph nodes destroys both lymphoid tissue and channels through which the T cells had traveled, thereby trapping these recirculating cells.⁶ Exercise studies have shown that these lymphocytes are not redistributed but are lost to the functioning T cell pool. Studies of normal patients show that recirculating lymphocytes are mobilized into the peripheral circulation after physical exertion. Sarcoidosis patients show some mobilization of recirculating lymphocytes but considerably less than the normal controls. This indicates that a proportion of their T cells have been removed from the available pool of functioning T cells.⁷

There is support for the hypothesis that delayed hypersensitivity suppression in sarcoidosis patients is secondary to an actual defect in T cell function. There is some disparity of opinion as to whether or not there is a defect in the ability of T cells from sarcoidosis patients to respond to nonspecific mitogens such as PHA. A recent study showed a normal response of T cells from sarcoidosis patients when exposed to PHA and concanavalin A.⁸ However, most investigations have revealed a decreased or poor response when such T cells are exposed to PHA.^{9,10} Siltzbach notes the correlation between the lack of response by cultured lymphocytes from sarcoidosis patients to nonspecific mitogens *in vitro* and suppressed reaction to PPD *in vivo*.¹¹ Lack of T cell response would seem to indicate an inherent T cell defect.

Causes of T Cell Dysfunction

Some possible causes for T cell dysfunction have been elucidated. Indirect immunofluorescence studies to determine if antibodies to T cells were present in sarcoidosis patients revealed IgG and IgM binding with T lymphocytes.¹² Sarcoidosis patient's sera caused cell death in 24% of donor T cells while control sera was toxic to less than 7% of donor cells. Such antibodies to T cells in sarcoidosis patient's sera might decrease the number of T cells through cell death or change them into the nonphagocytic atypical lymphocytes and thus render them nonfunctional.

Impaired delayed hypersensitivity may also be due to defective chemotaxis. Chemotactic factor inactivator may be an important modulator of inflammation.¹³ Defective chemotaxis associated with increased levels of chemotactic factor inactivator has been found in sarcoidosis patients.¹⁴

However, one study has shown that the delayed hypersensitivity response was abnormal even with direct intradermal injection of lymphokine.¹⁵ This would indicate that there is an additional factor affecting the inflammatory response beyond the inactivator of lymphokine concerned with chemotaxis.

More Questions

Finally, there is evidence of some additional unknown factor in the defective cell-mediated immune response. Mangi¹⁶ showed that sarcoidosis patients had an abnormal delayed hypersensitivity reaction to the skin test for *Candida albicans* but a normal *in vitro* lymphocyte response to the same antigen. This evidence implies that a minimum number of cells is not really needed for a delayed hypersensitivity response to the antigen nor are the cells defective in their ability to respond to a foreign antigen. However, the lymphocytes' normal *in vitro* response is not unreasonable when their removal from the presence of T cell antibodies and increased concentrations of chemotactic inactivator are considered.

Patients with sarcoidosis also may show an increase in the number of B cells and exaggerated humoral response to antigen. This phenomenon may be helpful in diagnosing the disease. Quinn¹⁷ showed a negative mumps skin test and a positive mumps complement fixation test to be so common in sarcoidosis patients that the combination of tests may be used investigatively to diagnose suspected cases. It is not diagnostic, however.

James¹⁸ noted abnormal immunoglobulin levels in 80% of patients with sarcoidosis with IgG most commonly elevated. An increase in circulating antibody to several viruses, including Epstein-Barr, measles, and rubella was also noted and confirms the nonspecific increase in circulating immunoglobulin. The cause of such an augmentation in B cell function is purely speculative.

Daniele and Rowlands¹⁹ suggest hypothesis involving the T cell antibodies. There is evidence that enhancer T cells may provide a substance that changes B cells into plasma cells which, in turn, produce immunoglobulins.²⁰ There are also suppressor T cells which would suppress the immunoglobulin production and create a balanced effect. This balance may be upset if the T cell antibodies were directed against the suppressor T cells. It would allow

unchecked function of the enhancer T cells creating an overproduction of immunoglobulin.

Another investigation revealed an enhancer substance released from sarcoidosis patient's circulating monocytes after antigenic stimulation. The substance increased B cell production of immunoglobulins in both normal and sarcoidosis patients.²¹ It also increased the reactivity of normal patient's T cells but did not affect T cells from sarcoidosis patients. Both hypotheses suggest that the immunoglobulin overproduction is secondary to extrinsic stimulation and not inherent B cell overactivity.

A positive Kviem-Siltzbach test, assumed to be an immunologic phenomenon, is another important feature of patients with sarcoidosis. The test involves injecting prepared human sarcoid tissue, usually from a lymph node or the spleen, into a patient suspected of having sarcoidosis. About 80% of those who do have sarcoidosis will show a granulomatous reaction at the site of the intradermal injection. Siltzbach²² speculates that the granuloma formation may be a deranged type of delayed hypersensitivity or a reaction secondary to an extremely unusual antigen. The substance in the injected sarcoid material which evokes the Kviem-Siltzbach reaction remains unknown. ◀

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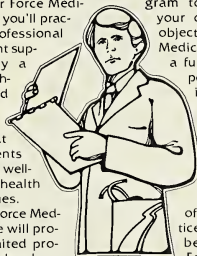
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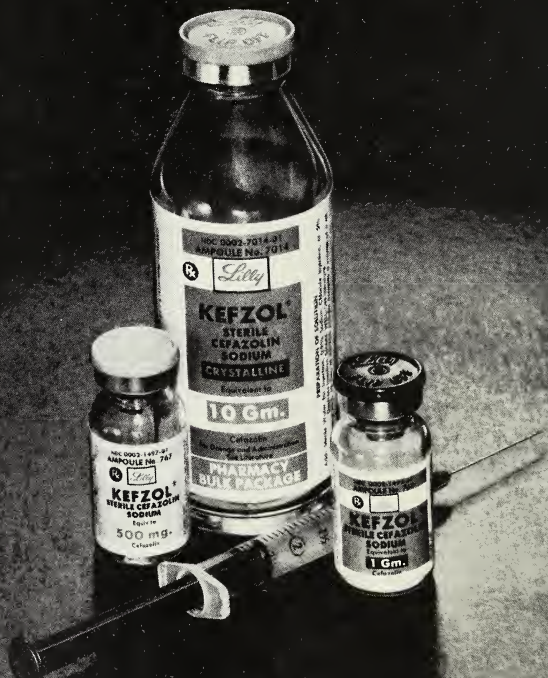
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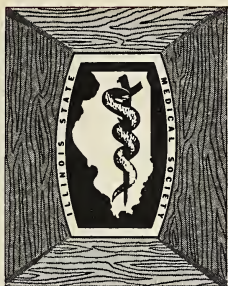
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Benign Variant of Familial Sea-Blue Histiocytosis

BY REDA M. SALAMA, M.D. AND JOSE L. PINO, M.D./STERLING AND BALTIMORE

A family with five cases of Sea-Blue Histiocytosis in the bone marrow is described. An autosomal dominant mode of inheritance is suggested. In contrast to previous reports, this family appears free of related symptoms. Three adult members of this family had diabetes mellitus, an association not previously reported in the literature.

"Blue pigment macrophages" were originally described by Moeschlin¹ in 1947: "The blue-stained granules are very fine and may be so

closely packed that the whole cell body appears blue; then the granules can only be recognized at the edges." The cells vary from 30-60 μ . He mentioned two patients, one with splenomegaly of uncertain etiology and another a case of suspected chronic malaria.

The condition characterized by these cells is "the Syndrome of the Sea-Blue Histiocytosis," first reported by Wewalka² and later popularized by Silverstein *et al*,³ who also defined the criteria for diagnosis.⁴ A number of different conditions were associated with the Syndrome of Sea-Blue Histiocytosis (Table 1). We describe here a symptom-free family with Sea-Blue Histiocytosis in the bone marrow.

Material and Methods

A family with Sea-Blue Histiocytosis was studied. Clinical examination included ophthalmological consultation. Laboratory studies on all patients included a complete blood count, platelet count using Coulter[®] Counter equipment, SMA[®] 12/60 chemistry profile, lipoprotein elec-



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trophoresis and serum acid phosphatase. A qualitative test for urinary mucopolysaccharides was also done. Each patient had a bone marrow aspiration and biopsy from the posterior iliac crest. A Jamshidi needle was used for the bone biopsies.⁵ One medium-sized particle of bone marrow aspirate was carefully distributed on each cover slip. These were spread with minimal squeezing and smears were stained by Wright-Giemsa stain. From each aspirate three smears with a technically acceptable quality were chosen. 3,000 cells were counted and percentage of Sea-Blue histiocytes was calculated.

Other smears were stained with the following stains: PAS,⁶ Oil red O,⁷ Toluidine blue,⁷ Alcian blue⁷, and Prussian blue.⁷ The smears were scanned for Sea-Blue histiocytes and positive or negative results were recorded. Appropriate controls were run.

Report of Cases

Case 1—Proposita, H.H., a 30-year-old Caucasian female, was referred for hematological evaluation because of anemia. Iron had been prescribed three days previously. She complained of fatigue and frequent headaches over the past six weeks. She had poor eating habits and survived mainly on potato chips and vegetables. Her menstrual periods were regular. A complete physical examination was normal and spleen and liver were of average size. The lungs were clear clinically and on radiological examination. Neurological and ophthalmological examinations were unremarkable. Laboratory data disclosed a hemoglobin of 7.8 g/dl, hematocrit 28%, reticulocyte count 0.8%, MCV 62 fl., MCH 28.9 g/dl. The stained blood smear showed microcytosis with marked anisocytosis, poikilocytosis and hypochromia. Platelets, fasting blood sugar, calcium, phosphorus, BUN, uric acid, total protein, albumin, bilirubin, alkaline phosphatase, LDH and GOT were normal. Bone marrow aspirate and bone biopsy revealed erythroid hyperplasia, absent iron stores and Sea-Blue histiocytes (Table 2). Cholesterol, triglycerides, lipoproteins, hemoglobin electrophoresis, folic acid, serum acid phosphatase and urinary mucopolysaccharides were normal. Platelet count was $280 \times 10^9/l$. Her latest blood count (after oral iron treatment) showed a hemoglobin of 13.1 g/dl and hematocrit of 40%. The liver biopsy showed no significant changes.

Case 2—B.H., the 43-year-old sister of the proposita, was known to have had mild diabetes for

12 years. She was not taking any medication. The only pertinent finding on examination was obesity, (weight of 259 lbs.) and her height, 64 inches. A small amount of drainage exuded from the left breast, originating in an abscess which had been drained two months previously. The liver and spleen were normal in size and lungs were clear. Her hemoglobin was 13.3 g/dl.

Table 1
Disorders associated with Sea-Blue Histiocytosis in the bone marrow.

- A) With hepatosplenomegaly:
 - 1) The syndrome of Sea-Blue Histiocytosis or Silverstein's syndrome.
- B) With predominant neurological manifestations:
 - 1) Progressive central nervous system degeneration with ceroid storage.
 - 2) Sea-Blue Histiocytosis associated with posterior column dysfunction in childhood.
 - 3) Familial Sea-Blue Histiocytosis with acid phosphatemia.
 - 4) Vertical supranuclear ophthalmoplegia with neurovisceral storage.
- C) With predominant skin manifestations:
 - 1) Vascular pseudohemophilia associated with ceroid pigmentophagia in albinos.
- D) With lipid disorders.
 - 1) Familial lecithin: cholesterol acyltransferase deficiency.
- E) Drug induced:
 - 1) Secondary to ingestion of 4, 4-diethylaminoethoxy-hexaester dihydrochloride.
- F) With hematologic disorders:
 - 1) Sickle cell anemia.
 - 2) Polycythemia vera.
 - 3) Idiopathic thrombocytopenic purpura.
 - 4) DiGuglielmo's syndrome.
 - 5) Chronic granulocytic leukemia.
 - 6) Mycosis fungoides.
 - 7) Multiple myeloma.
 - 8) Hodgkin's disease.
- G) Asymptomatic:
 - 1) Idiopathic benign familial Sea-Blue Histiocytosis.

hematocrit 42.3%, platelets, $203 \times 10^9/l$. Lipoprotein electrophoresis, serum acid phosphatase and urinary mucopolysaccharides were normal. Fasting blood sugar was 89mg% while other blood chemistries were unremarkable. Bone marrow aspirate and bone biopsy showed Sea-Blue histiocytes.

Case 3—D.M., proposita's brother was asymptomatic.

matic but known to have had mild diabetes mellitus for four years. A complete physical examination found no abnormalities. The liver and spleen were not enlarged. The hemoglobin was 14.2 g/dl. and the hematocrit 42.6%. Platelets were $246 \times 10^9/l$. The two-hour post-prandial blood sugar was 140 mg%, triglycerides 257 mg%, cholesterol 215 mg%, with normal serum

Table 2

Patient	No. of Sea-Blue Histiocytes per 3000 cells	Percentage
Case 1* H.H.	164	5.5%
Case 2* B.H.	34	1.1%
Case 3* D.M.	195	6.5%
Case 4* K.M.	13	0.4%
Case 5* R.H.	27	0.9%

*Homozygous

*Heterozygous

acid phosphatase and normal urinary mucopolysaccharides. Other blood chemistries were not unusual. Bone marrow aspirate and bone biopsy revealed numerous Sea-Blue histiocytes.

Case 4—K.M., the 8-year-old son of Case 3, was asymptomatic excepting a mild speech defect. The complete physical examination was unremarkable. The liver and spleen were not enlarged, hemoglobin was 12.7 g/dl., hematocrit 38.2% and platelets were $408 \times 10^9/l$. Bone marrow aspirate and bone biopsy revealed a small number of Sea-Blue histiocytes. Serum acid phosphatase and urinary mucopolysaccharides were normal, as well as other blood chemistries.

Case 5—R. H., 11-year-old son of the *proposita*, was asymptomatic and had an unremarkable past history. Excepting two iris cysts, a complete physical examination was uneventful. The spleen and liver were not enlarged. Hemoglobin was 13.1 g/dl., hematocrit 40% and platelets, $309 \times 10^9/l$. Lipoprotein studies, serum acid phosphatase and urinary mucopolysaccharides were within accepted limits. Other blood chemistries also showed no abnormalities. Bone marrow aspirate and bone biopsy revealed a small number of Sea-Blue histiocytes.

The father, one brother, two daughters, one son and two nephews of the *proposita* were also examined, including bone marrow aspiration and bone biopsies. They showed no evidence of Sea-Blue Histiocytosis. A 48-year-old brother and four of his children were known to be healthy, but they have not been examined. There is no history of intermarriage between any of the family

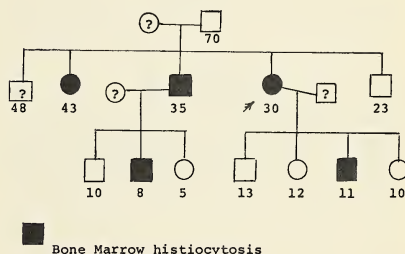


Figure 1

Pedigree of Sea-Blue Histiocytosis in the instant family.

members. The mother of the *proposita* died when she was 50 years old as a result of long-standing diabetes.

Results

The pedigree of the family is shown in Figure 1. Two types of cells were found in the marrow. Both were as previously described by Malinin.⁸ One has an eccentrically placed nucleus with the cytoplasm deeply packed with dark sea-blue granules; the other shows a foamy cytoplasm with dark blue granules. The number of cells in the affected members of the family is shown in Table 2. Histochemical studies revealed positive-staining with PAS and negative results with Toluidine blue, Alcian blue and stain for iron. The oil red O and Sudan black indicates the presence of lipids. The negative reaction to Toluidine blue indicates no significant amount of nucleoprotein. The negative Alcian blue reaction indicates the absence of acid mucopolysaccharides. With the Giemsa stain the histiocytes appear to have a brown color.

Discussion

We present here a study of a family with

Sea-Blue histiocytes in the bone marrow. We attempted to quantify marrow involvement, implementing rigidly controlled method to compensate for the concentration of Sea-Blue histiocytes in and around marrow spicules. This method revealed a remarkable suggestion of heterozygosity (cases 2, 4 and 5) versus homozygosity (cases 1 and 3). We suggest this method for broad family studies with this syndrome to clarify the genetics of Sea-Blue Histiocytosis. An autosomal dominant pattern of inheritance in this family is suggested.

This case report describes a family with none of the conditions common to this syndrome and emphasizes that Sea-Blue histiocytes in the bone marrow are not necessarily associated with any clinical syndrome. The only disease which occurred at a higher than usual frequency was diabetes mellitus, and although diabetes is a common disease, an association cannot be completely excluded. This has not been described to our knowledge. Foam cells and cells loaded with lipid have been described in the marrow of patients with hyperlipoproteinemias Type I⁹ and Type V.^{10,11} However, on reviewing the literature we did not find characteristic Sea-Blue histiocytes in these diseases. Also, none of our patients had any hyperlipoproteinemia.

Review of Literature

Sea-Blue histiocytes have been found in the bone marrow in a variety of disorders. Four different conditions have been described with Sea-Blue histiocytes in which neurological manifestations predominate.

Progressive central nervous system degeneration and café au lait spots were described in a female who died at 42 months. In this patient ceroid pigment was found in the cytoplasm of neurones, astrocytes and macrophages of the brain as well as in renal, hepatic and intestinal tissues. A brother died of a similar disease at five years of age.¹²

A 17-year-old girl with posterior column dysfunction and ceroid-lipofuscin-type of material present in the liver and rectal ganglion cells was described by Swaiman *et al.*¹³ Low serum vitamin E levels were found, but there was a normal absorption of vitamin E and no clinical response to its administration. An older sister with neurological disease could not be examined.

A progressive neurological disease with vertical supranuclear ophthalmoplegia and visceral involvement has been described by Neville *et al.*¹⁴

They describe nine patients and added nine more from a review of the literature. Neurological deterioration suggesting diffuse nervous system involvement started after the first year of life. Nine patients had splenomegaly and seven had hepatomegaly. A large increase of sphingomyelin was found in the spleen of one of the patients. However, sphingomyelinase activity was normal here and also in four other patients, suggesting an autosomal recessive trait.

A unique family with peripheral neuropathy, splenomegaly, café au lait spots and elevated serum acid phosphatase was described by Blankenship *et al.*¹⁵ The age of the three affected children were 17, 18 and 22 years. Parents were clinically normal but the father had Sea-Blue histiocytes in the bone marrow and an elevated bone marrow acid phosphatase.

The association of albinism and a hemorrhagic diathesis was reported by Hermansky *et al.*^{16,17} One of the patients was a woman with a hemorrhagic condition since childhood. She died at age 38 of a subdural hemorrhage. Ceroid-laden pigmentophages were encountered in the blood vessels at autopsy. The occurrence of bleeding could reflect accidental rupture of the blood vessel walls secondary to fragile endothelial cells transformed into pigmentophages.

Further Research

The only syndrome with Sea-Blue Histiocytosis of well established etiology is the familial lecithin, cholesterol acyl-transferase deficiency.¹⁸ These patients have diffuse corneal opacities, moderate anemia with target cells in the peripheral blood, proteinuria, and a variety of lipoprotein changes in the serum.

The finding of drug induced Sea-Blue Histiocytosis by Imoto *et al.*¹⁹ broadened the clinical spectrum of this morphologically striking cell. A defect in sterol metabolism induced by the vasodilator 4, 4-diethylaminoethoxyhexaoesterol dihydrochloride is suggested.

Kattlove *et al.*²⁰ pointed out the association of Sea-Blue histiocytes in the marrow and conditions with an increased turnover of hematologic cells including: sickle cell anemia,²⁰ polycythemia vera,²¹ idiopathic thrombocytopenic purpura,²² DiGuglielmo syndrome,²³ chronic granulocytic leukemia,²⁴ mycosis fungoides,²⁵ multiple myeloma,²⁶ and Hodgkin's disease.²⁷ It is of interest that the two siblings reported by Quattrin *et al.*²⁸ with thrombocytopenic purpura had an asymptomatic sister with Sea-Blue histiocytes in

the marrow, pointing out a possibly coincidental association of these cells with hematologic disorders.

Histochemical studies characterize the storage material as ceroid, a pigment which reacts with fat stains and is insoluble in a variety of hydrocarbons that dissolve normal lipids.²⁹ Hepatic lipid analysis in the syndrome of Sea-Blue Histiocytosis revealed increased amounts of glycolipids and sphingomyelin, and unidentified phospholipid accounted for 12% of the hepatic lipids.³ One patient's spleen had increased amounts of cerebroside and sphingomyelin. In the same syndrome Sawitsky *et al.*³⁰ found the spleen sphingomyelin content increased almost four times as related to the lecithin content.

In the syndrome of progressive central nervous system degeneration with ceroid storage described by Levine *et al.*,¹² splenic tissue analysis suggested that highly oxidized polymers of unsaturated fat could be present. In the syndrome of vertical supranuclear ophthalmoplegia with neurovisceral storage,¹⁴ the spleen of one patient showed a marked increase in sphingomyelin content, sphingomyelin representing 49.4% of the total phospholipids (mean normal is 11.84%).

Electron microscopic examination of Sea-Blue histiocytes has shown numerous granules of different size and shape with a lamellar concentric structure. The periodicity of these membranes varies between 50 and 90 Å.³¹ It is interesting that similar lamellated structures have been reported in diseased neurons in Tay-Sachs disease,³² lymph nodes in Niemann-Pick disease,³³ Sea-Blue histiocytes in familial lecithin, cholesterol acyltransferase deficiency,¹⁸ and diseased neurons in the syndrome of progressive central nervous system degeneration with ceroid accumulation.¹² In Tay-Sachs disease the periodicity of the membranes is between 50 to 60 Å and in the Niemann-Pick disease between 40 and 45 Å. The difference in cytoplasmic granule periodicity has been interpreted as a reflection of the different composition of the cytoplasmic granules. In contrast, in the Sea-Blue histiocytes of sickle cell anemia numerous membrane-bound inclusions containing whole erythrocytes, small electron dense bodies and fine fibrils were found.²⁰ In idiopathic thrombocytopenic purpura, splenic histiocytes revealed non-membrane-bound electron dense bodies.²²

The increased sphingomyelin content in vertical supranuclear ophthalmoplegia with neurovisceral storage¹⁵ and Sea-Blue Histiocytosis,³⁴ encourages their inclusion among the sphingo-

lipidoses. We want to emphasize that this review concerns only cases with typical Sea-Blue histiocytes in bone marrow smears stained with Wright's stain. We have deliberately excluded disorders with macrophages filled with ceroid-like substances in the spleen or other organs unless associated with characteristic Sea-Blue histiocytes in bone marrow smears. ◀

References

A complete list of references for "Benign Variant of Familial Sea-Blue Histiocytosis" may be obtained by writing the Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, 60603.

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Hand Paresthesias after Racquetball

Case Presentation

A 33-year-old physician was seen for unilateral hand paresthesias. He had noted onset of tingling in the tips of his right thumb and index finger three weeks before. Over the next two weeks this progressed to involve the palmar surface of the first three fingers and the thenar eminence. The sensation's character changed to pain and burning. He noted loss of finger sensation and a sense of clumsiness about the hand. Wrist flexion caused shooting pains into the area involved. Symptoms were worse in the evening, but did not awaken him at night. Occasionally the pain would radiate to the elbow. Onset of symptoms had been concomitant with an increase in racquetball playing time from once to three times per week. The patient is right-handed. He had experienced no similar episodes in the past. There was no prior history of trauma or other joint disease. Other past history and review of systems were unremarkable.

On examination the right hand appeared grossly normal. There was no soft tissue swelling. The small joints of the right hand and fingers had normal range of motion. Decreased sensation to pinprick was noted over the palmar surface of the thumb, index and middle fingers. No hyperesthesia was noted. There was tenderness to palpation over the wrist crease. Muscular strength and coordination were normal. The left hand was normal to similar exam. Tinel's and Phelan's signs were positive on the right. Sensory and motor testing of the right forearm, upper arm, shoulder and neck were normal. Adson's maneuver was negative. Cervical spine motion was normal, as was the rest of the physical exam.

Laboratory

Complete blood count and SMA 18 were normal. The sedimentation rate was 5 mm/hr.

Rheumatoid factor and antinuclear antibodies were absent. Fasting and two hour post prandial blood sugars were normal. X-rays of the cervical spine and both wrists were normal. Electromyography of the hand revealed decreased amplitude of median nerve conduction on the right with slowing across the wrist.

Comment

Median nerve compression at the wrist causes classic sensory and motor symptoms known as the carpal tunnel syndrome. Bordered by the transverse carpal ligament above and the flexor

Table 1

Causes of Carpal Tunnel Syndrome	
Bone Alteration	Tumor/Masses
Congenital	Lipoma
Carpal bone fracture	Ganglion
Acromegaly	Tophi
	Hemangioma
Tendon Sheath Swelling	
Rheumatoid arthritis	Infiltrative
Systemic lupus erythematosus	Amyloid
Traumatic synovitis	
Soft Tissue Swelling	Idiopathic
Trauma	Diabetes
Myxedema	Post-menopausal
Pregnancy	Other

tendon sheaths and carpal bones below, the median nerve passes through a rigid space at the volar surface at the wrist crease that is easily narrowed. Alterations of bone structure,¹ swelling^{2,3} or infiltration^{3,4} of soft tissues, and small tumors or masses^{4,5} may cause such narrowing with resultant compression of the median nerve (see Table 1). The majority, however, occur idiopathically in post-menopausal women where biopsy reveals only chronic scar tissue.⁶

Paresthesia and dysesthesia are the most common complaints. The sensation is described as shooting, tingling and burning in the distribution of cutaneous innervation of the median nerve. Pain may radiate to the elbow but the only objective signs are those distal to the wrist crease. The hand may be clumsy due to sensory loss. Symptoms are often exacerbated by activities which cause wrist flexion (knitting, reading, driving) and are often relieved by vigorous shaking of the hands. Patients frequently sleep with their wrists flexed and awake abruptly in pain. Taping the median nerve at the wrist (tincl) or holding the wrist in forced flexion for 30 seconds (phelan) may reproduce the shooting pain. A swelling of the nerve may be noted proximal to the wrist crease. Sensory symptoms are often insidious in onset,⁶ and motor symptoms of thenar weakness and atrophy have time to develop in almost half of patients before they present. The disease is often bilateral. It is important to note that thoracic outlet syndromes and cervical spine disease may mimic carpal tunnel syndrome.

The clinical diagnosis of carpal tunnel syndrome is based on classic symptoms and signs. A positive electromyogram confirms diagnosis. Work-up should be aimed at defining the underlying etiology. Initial treatment depends on severity of disease.⁶ If thenar atrophy is absent, immobilization in a wrist splint and analgesics may be tried. Oral anti-inflammatory agents and a local injection of steroids above the nerve in the carpal tunnel should be employed if symptoms do not abate rapidly. The injection may be repeated once. Thenar atrophy or persistent symptoms require surgery for resection of the transverse carpal ligament. This is almost always helpful for sensory symptoms, and may reverse motor nerve damage to some degree. Tissue should always be sent for pathological study. Obviously, an underlying disease should be treated appropriately.

Conclusion

The typical pattern of sensory symptoms in our patient's hand suggested carpal tunnel syndrome. The positive phelans and tincl sign and the abnormal electromyogram confirmed this diagnosis. Physical examination and laboratory screening elicited no evidence of systemic disease. The temporal relationship to racquetball suggested the etiology. Multiple forceful flexion with the racquet probably caused a tenosynovitis at the wrist with flexor tendon swelling in the

carpal tunnel and subsequent nerve compression. We have seen a similar case in a patient who threw hard curve balls repeatedly on the first day of the baseball season. The patient was treated with wrist splinting and indomethacin which induced an initial reduction of symptoms after one week. Because of persistent mild paresthesias, locally injected steroids were employed and symptoms completely relieved. ◀

References

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Homicide Investigation

On July 19, 1977 at 2:20 p.m., a caretaker found a deceased infant wrapped in plastic and buried in a shallow grave at a local cemetery. The victim is a full term female caucasian, hydrocephalic infant, 47 cm. in length, 5½ pounds, with the umbilical cord still attached. The infant has been deceased for 1 to 6 months, with emphasis on 1 to 2 months.

To our knowledge, the infant was not born in a hospital, and the mother may have needed medical attention for hemorrhaging, vaginal or rectal tears, or shock. Infection may have been present.

Although I recognize the importance of confidentiality in the normal doctor-patient relationship, due to the unusual circumstances of this case, I am asking for whatever assistance one may be able to provide. Anyone having information, or needing additional data please contact Barrington Chief Howard Peek or the Major Crimes Unit at 312-381-2141. All contacts are held in confidence. (Ref. CR 77-0814).

MORBIDITY AND MORTALITY WEEKLY REPORT

Tuberculosis — United States, 1976

Tuberculosis is among those diseases which have received little publicity over recent years. These figures, reprinted from an HEW Center for Disease Control Public Health Service report, represent final statistics for 1975 and 1976. They clearly demonstrate that Tuberculosis incidence is on the rise in Illinois, which ranked 29th in 1975 and 21st in 1976 tabulations of cases reported.

Final figures on the incidence of tuberculosis in the United States in 1976 have now been reported to CDC (for provisional figures, see MMWR 26[8], 1977). Last year there were 32,105 recorded cases, a decline of 5.5% from the 33,989 cases reported in 1975 (Table 3). The case rate was 15.0 per 100,000 population, down 5.7% from the 1975 case rate of 15.9.

The geographic disparity in distribution of cases is reflected in the fact that 9 states each had

more than 1,000 cases, whereas 14 states each had less than 100 cases. Eight states and the District of Columbia had case rates exceeding 20 per 100,000, while 6 states had case rates below 5 per 100,000. As in 1975, Hawaii had the highest case rate and Nebraska the lowest.

Reported by the Tuberculosis Control Div., Bur. of State Services, CDC.

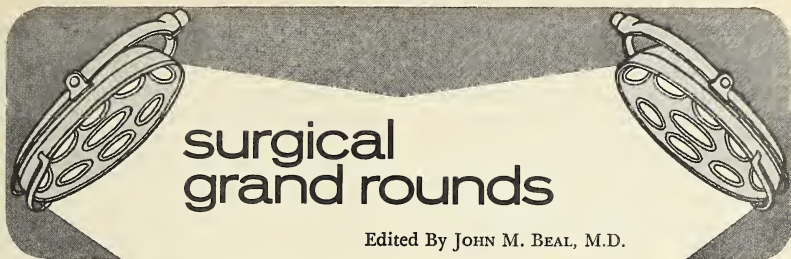
TABLE 3. Tuberculosis cases, rates,* and ranks,** final figures by state, 1975 and 1976

STATE	1975			1976	Case Rate	Rank	STATE	1975			1976	Case Rate	Rank
	Total Cases	Case Rate	Rank	Total Cases				Total Cases	Case Rate	Rank	Total Cases	Case Rate	Rank
UNITED STATES	33,989	15.9	—	32,105	15.0	—	Missouri	550	11.5	31	568	11.9	27
Alabama	780	21.6	7	824	22.5	3	Montana	94	12.6	27	51	6.8	38
Alaska	74	21.0	11	88	23.0	2	Nebraska	40	2.6	50	58	3.7	50
Arizona	422	19.0	13	405	17.8	12	Nevada	36	6.1	42	42	6.9	37
Arkansas	501	23.7	4	444	21.1	7	New Hampshire	30	3.7	49	34	4.1	48
California	3,633	17.1	18	3,620	16.8	15	New Jersey	1,271	17.4	17	1,201	16.4	17
Colorado	220	8.7	35	174	6.7	39	New Mexico	146	12.7	26	181	15.5	20
Connecticut	240	7.8	38	227	7.3	36	New York	3,934	21.7	6	3,072	17.0	14
Delaware	101	17.4	16	82	14.1	25	North Carolina	1,166	21.4	8	1,220	22.3	5
Dist of Col.†	382	53.4	—	319	45.4	—	North Dakota	25	3.9	48	40	6.2	41
Florida	1,758	21.0	10	1,630	19.4	10	Ohio	1,200	11.2	33	926	8.7	33
Georgia	1,031	20.9	12	824	16.6	16	Oklahoma	369	13.6	23	399	14.4	24
Hawaii	591	68.3	1	665	75.0	1	Oregon	194	8.5	37	197	8.5	34
Idaho	36	4.4	46	37	4.5	47	Pennsylvania	1,540	13.0	24	1,511	12.7	26
Illinois	1,345	12.1	29	1,711	15.2	21	Rhode Island	120	12.9	25	82	8.8	32
Indiana	607	11.4	32	544	10.3	30	South Carolina	627	22.2	5	589	20.7	8
Iowa	125	4.4	47	115	4.0	49	South Dakota	72	10.5	34	62	9.0	31
Kansas	194	8.6	36	135	5.8	42	Tennessee	1,033	24.7	3	902	21.4	6
Kentucky	642	18.9	14	586	17.1	13	Texas	2,600	21.2	9	2,454	19.7	9
Louisiana	593	15.6	20	614	16.0	19	Utah	60	5.0	44	60	4.9	45
Maine	78	7.4	39	72	6.7	40	Vermont	31	6.6	41	36	7.6	35
Maryland	1,035	25.3	2	925	22.3	4	Virginia	908	18.3	15	821	16.3	18
Massachusetts	719	12.3	28	676	11.6	28	Washington	427	12.0	30	378	10.5	29
Michigan	1,271	13.9	22	1,349	14.8	22	West Virginia	263	14.6	21	263	14.4	23
Minnesota	194	4.9	45	213	5.4	43	Wisconsin	264	5.7	43	225	4.9	46
Mississippi	390	16.6	19	434	18.4	11	Wyoming	27	7.2	40	20	5.1	44

* Rates per 100,000 population

** By Rate

† District of Columbia is not ranked with the States but is included in totals



Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of March 1, 1977.

Case Report

Pulmonary Embolism

Dr. Renee Hartz: A 33-year-old white woman arrived in the Northwestern Memorial Hospital Emergency Room January 31, 1977, with the chief complaint of severe shortness of breath. One week earlier, she had had a three-hour episode of severe right-sided chest pain associated with respiration. She also complained of a dry, non-productive cough. The patient remained home for a few days, but on the day of admission had returned to her job, feeling better but weak and without chest pain. However, shortly after arriving at work, she became very weak, collapsed and lost consciousness. She was seen by her company physician, who transferred her by ambulance to the hospital emergency room. Further additional history obtained in the Emergency Room was that she had taken birth control pills for ten years. She specifically denied any leg pain during these episodes or at any time in the past.

Physical examination at emergency room admission: Blood pressure, 60 mm Hg systolic, heart rate of 130; evidence of peripheral vasoconstriction and cardiac enlargement. Lungs

were clear. Her lower extremities were negative for signs of inflammation or venous thrombosis.

The patient was immediately transferred to the Medical Intensive Care Unit and was scheduled for a ventilation perfusion lung scan. However, her pressure deteriorated from a systolic of 60 to one of 30 and the lung scan was cancelled. The patient was resuscitated with intravenous fluid including albumin initially and then dopamine. Her central venous pressure increased to 25. Consultation was obtained for a possible pulmonary arteriogram. Before the decision was made, patient's blood pressure became imperceptible and cardiopulmonary resuscitation was instituted with closed chest massage.

The operating room was made ready for cardiopulmonary bypass and possible pulmonary embolectomy.

Dr. John Beal: I would like to ask Dr. Lesch to comment. He is Chief of the division of cardiology in the department of medicine.

Dr. Michael Lesch: The problem with pulmonary embolism from the medical point of view is not to diagnose the obvious major em-

bolus, since it is difficult to miss this type of case. The problem for us relates to the subtle forms of this disease.

I will present some data which has come from the recent urokinase pulmonary embolism trial. In 1968-72, the NIH performed a control study on the differential effect of heparin versus urokinase in the treatment of pulmonary embolism. In order to participate, patients had to have a battery of hemodynamic tests, angiograms, and scans. They also needed follow-up angiograms and scans and clinical evaluation. The net result: in addition to learning a lot about what urokinase and heparin does to the natural course of pulmonary embolism, we learned a lot about pulmonary embolism. It has taught us as internists and medical physicians to be extremely wary of what is presented in textbooks.

Mortality Rates

The issue is very clearly stated in terms of the mortality of untreated pulmonary embolism, taking all patients, whether massive or submassive, in whom embolism occurred. From a number of series that are primarily autopsy studies, the data indicates a mortality in the range of 30%. In the United States, there are 630,000 pulmonary emboli per annum, of which 67,000 or 11% are dead within an hour. Of the 89% that survive, the diagnosis probably is not made in 400,000. In this group of 400,000, there is a 30% mortality; namely 120,000 people. In those patients in whom the diagnosis is made, or an estimated 163,000 (29% of the total), we are dealing with a 92% survival and 8% death. Therefore, the therapy we have available at this time is very effective. The problem is to make the diagnosis. Again, I believe this afternoon's patient is at the far end of the spectrum in terms of presentation. I doubt that many people would miss the diagnosis and I think that my division should have moved more quickly to angiography.

At one time, pulmonary embolic disease was suspected in any examination showing unexplained dyspnea, chest pain, hemoptysis, left ventricular failure, intractable heart failure or deterioration or chronic lung disease. These factors are all still true; unfortunately, there are just some sick people in the hospital. Anyone in a hospital merits a high index of suspicion apropos pulmonary embolism.

The diagnostic work-up suggested by textbooks was chest X-ray, electrocardiogram, white

count and some blood chemistries. Then, depending on these findings, the examination moved into pulmonary function and then arterial blood gas studies, cardiac catheterization, pulmonary angiogram and lung scan. This became the screening mechanism. If the first studies were negative, you presumably did not need the more definitive studies. We shall see that this approach is far from correct.

Urokinase pulmonary embolism trial (UPET) data examined for prevalence of various symptoms on presentation shows only 81% had dyspnea. One can say that 19% of those with pulmonary embolism did not have dyspnea (of those with massive pulmonary embolism, actually one-fifth of them did not have dyspnea). Dyspnea was the one finding that was present most frequently. If one goes to the other common symptoms of pulmonary embolism, pleural pain, apprehension, cough, hemoptysis, sweats, or syncope, it becomes obvious that we're falling to very small numbers. Fifty percent with cough, only 27% with hemoptysis—and this is the group with massive pulmonary embolism.

Massive vs. Submassive

There were two interesting findings in terms of the differential between massive and submassive. Pleural pain was found significantly more times in the patients with submassive pulmonary embolism. Presumably, this represents a peripheral embolus which gets out to a peripheral branch of the pulmonary artery, where one can actually have pleural involvement. Certainly syncope was found in more patients with massive pulmonary embolism than with submassive. In short, however, all the signs previously employed for suggesting the diagnosis of pulmonary embolism are quite suspect.

We then go on to presenting signs. Again, rates only 53%, increased PO_2 only 53%, objective evidence of phlebitis, 33%. I would remind you that this is clinical evidence of phlebitis. Eighty-seven percent did have some degree of tachypnea which has proven to be probably the most accurate, or at least the most frequent finding in these patients. Tachycardia, only 40% and fever was 42%.

If one looks at the classic laboratory findings as they stood in 1968-69, I think it is clear that less than 40% had any of the previously defined screening tests. If these parameters were used to

define whether a more vigorous diagnostic work-up was appropriate, 60% of the cases would be overlooked.

Electrocardiographic manifestations were studied in all these patients who had pulmonary embolism without prior cardiac or pulmonary disease. Only 13% had a normal ECG, but only 2.5% had any of the findings that we associate with classic pulmonary embolism (e.g., right axis deviation, incomplete right bundle branch block in the S1Q3 pattern). The usual findings on the ECG are not insufficiently specific; they are present less than 10% of the time. One cannot really make a diagnosis on the basis of physical history or electrocardiogram.

Some Hemodynamic Variables

Let us consider a variety of hemodynamic variables in pulmonary embolism. If 90% saturation is considered normal for arteriolar oxygenation, patients with pulmonary embolism and no previous disease were abnormal by this test. If one looks at pulmonary artery (PA) pressure, there are some patients with large pulmonary embolism who had very low pulmonary artery pressure. The other point worth noting is that one finds no PA pressure greater than 40 mm of mercury. The explanation for this is that the normal ventricle cannot generate more than 40 mm of mercury pressure when an acute load is placed upon it. A large clot in this situation with near total obstruction would simply cause cardiopulmonary arrest, as we saw in today's patient.

The other factor about pulmonary embolism which has been recognized is that 95% of patients with embolus have deep venous thrombosis (DVT). Of patients with DVT, only 50% have the classic clinical signs of DVT. Presumably, today's patient had DVT, but on physical examination, her legs were normal. Of patients with the classical findings of thrombosis, Homan's sign, inflammation, etc., only 50% do have DVT.

Thus, DVT is a reliable indicator. The odds of pulmonary embolism are very high, but clinical ability to diagnose DVT is not adequate and a more accurate diagnostic method is needed. Our present day approach is to start heparin immediately if one suspects a pulmonary embolism. As I showed you, one can reduce a 30% mortality to 8% with this treatment alone.

Once the patient is somewhat protected with

heparin, the diagnosis depends upon whether there is DVT or not. If you have no DVT as defined by appropriate tests, one can rule out pulmonary embolism. Arterial oxygenation can be used as another index; if the patient has no existing cardiovascular disease and arterial saturation is above 90 or 95%, pulmonary embolism is effectively ruled out. If there is evidence of DVT or arterial desaturation, one should proceed to a lung scan and pulmonary angiography.

Dr. John Beal: Dr. Harvey Takaki will speak on another aspect of this problem.

Inferior Vena Cava Clipping

Dr. Harvey Takaki: To introduce the subject of inferior vena cava clippings, I would like to present a case with which we were recently confronted. A 55-year-old Caucasian man presented in January 1977 at Wesley Pavilion, complaining of difficulty with his right knee. On January 5, he underwent a right medial meniscectomy without difficulty. His past medical history was essentially unremarkable and he had no prior history of thrombophlebitis. Ten days postoperatively, following his discharge, he returned to the emergency room with fever, shaking chills, and a right knee effusion. On the third hospital day, incision and drainage was performed of the right knee and staph epidermidis was the causative agent. He was started on Nafcillin and subsequently switched to Penicillin G.

On the tenth postoperative day, he first complained of right calf pain and swelling. A venous flow study was performed at that time. The patient was begun on continuous infusion of heparin. The venous flow study demonstrated normal respiratory variation over the left femoral and the left popliteal veins. On the right side there was diminished respiratory variation over the right common femoral vein. In addition, respiratory variation over the right popliteal vein was absent. Impedance plethysmography indicated an abnormal pattern on the right as opposed to a normal pattern on the left. On the basis of the venous flow studies, the diagnosis was made of acute right popliteal vein thrombosis, and heparin was appropriately started.

On January 30, the patient first complained of anterior pleuritic chest pain. Artificial blood gases were done at that time, revealing a PO_2 of 71 on room air. Lung scan was obtained and was reported as negative and the patient was continued on heparin. He had no further difficulty with chest pain. He did, however, com-

plain of consistent episodic periods of coughing.

On February 10, 1977, the patient developed rather abrupt onset of bilateral thigh swelling and in addition, complained of left calf pain while on heparin therapy. Venous flow studies were repeated and on the basis of the flow studies and clinical examination, bilateral contrast venography and inferior vena cavography were recommended. The second venous flow study demonstrated, as before, absence of respiratory variation in the right popliteal vein. In addition, the left common and popliteal veins were abnormal. Impedance plethysmography on the right was abnormal and now was abnormal on the left. Bilateral contrast venography revealed the deep venous systems on both sides to be totally occluded. On the right leg, there was a short segment of popliteal vein that was visualized containing long thrombi. On the left side, there was no popliteal vein visualized at all. Superficial venous plexes were noted. In the left groin, the greater saphenous vein was visualized, but there was no visualization of the femoral vein on the left or of the iliac vein. A similar picture was found on the right.

With a diagnosis of Inferior Vena Cava Occlusion, catheterization was performed through the right brachial vein, through the right atrium and down the upper inferior vena cava. It was noted by the catheterization team at the time of this study that the right atrium was exquisitely sensitive; the patient would easily go into premature atrial tachycardia and in addition there was a suggestion of right atrial pressure elevation. The upper vena cava is demonstrated on this study. The inferior vena cava was indeed totally occluded and, in addition, there was a long tail of thrombus extending up the upper vena cava. (Figure 1) Because of the presence of what appeared to be clinically pulmonary emboli while on heparin therapy and because of the venography demonstrating the proximal extension of the thrombus, operative intervention was recommended. A transperitoneal route was chosen to gain greater accessibility to the upper vena cava. It should be noted that at the time of the operation, the cardiac surgical team, including Doctor Sanders and the bypass team and bypass equipment were available in the operating room.

On exploration of the abdomen, there was no obvious pathology. Kocher maneuver was performed reflecting the duodenum and upper vena cava was mobilized high above the renal veins. A Satinsky clamp was placed across the

cava. A venotomy was then made into the vena cava and a large tail of thrombus was easily extruded. After it was clear that the inferior vena cava no longer contained thrombus, the venotomy was closed and a DeWeese clip was placed in the inferior vena cava below the right renal vein.

Postoperatively, the patient was continued on heparin; he developed moderately severe swelling in both legs, which responded to leg elevation and elastic ace bandages from toe to groin.

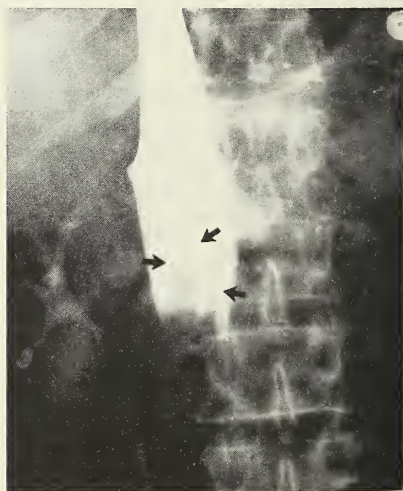


Figure 1.

Occlusion of inferior vena cava by thrombus demonstrated by catheterization through right brachial vein.

He was discharged two weeks following surgery in good health with mid thigh elastic stocking and on Coumadin.

The source of most pulmonary emboli is the iliac veins or the distal venous tree in approximately 85% of patients. In 15%, the embolus arises from the right atrium pelvic veins, vena cava or the upper extremity.

The importance of vena cava interruption in the prevention of pulmonary emboli has been emphasized since 1935. A number of techniques

have been employed through the years. Vena cava ligation has declined in popularity because of its potential for intraoperative hypotension, alteration of distal venous hemodynamics on animal studies and primarily because of its resultant development of large collaterals around the cava which can act as potential routes for recurrent emboli. At present, vena cava clipping and, more recently, intracaval devices such as the umbrella and Greenfield's cone have gained popularity.

As Doctor Lesch has mentioned, it should be emphasized that heparin is the primary treatment for uncomplicated pulmonary embolism. Strict criteria are followed in the selection of patients for vena caval interruption. Recurrent pulmonary embolism while on adequate anticoagulation has been found to be the most frequent indication for caval surgery. In the situation of the first patient, following her successful pulmonary embolectomy, the inferior vena cava was clipped.

Operative Approach

The operative approach employed from IVC clipping at Northwestern is that of a right flank muscle splitting retroperitoneal approach. The initial skin incision has been modified to be a straight transverse one. The abdominal muscles are split along their fibers. Using the iliac fossa as a guide to the retroperitoneal space, the peritoneum is reflected medially and the vena cava is exposed. Once the cava has been adequately mobilized, a DeWeese Teflon clip is passed around the cava and tied in place. Vena caval operations at Northwestern recently have been reviewed and include 131 patients over an 18-year time span. Sixty patients underwent vena caval ligation; 42 patients, plication and suture filter; 31 patients underwent vena caval clipping.

The mortality for these procedures are essentially similar. In addition, late stasis sequelae including venous ulceration or severe chronic deep venous insufficiency are approximately the same. Although there is no absolute protection from recurrent emboli, vena cava clipping as currently employed at Northwestern has the advantages of comparable results with ligation and suture plication, operative simplicity and maintains patency of the vena cava.

Dr. John Sanders: The operative approach for massive pulmonary embolus really dates back to Doctor Trendelenburg, who first proposed the

removal of a massive pulmonary embolus using the technique of inflow occlusion. While this was proposed, it was a good number of years before anyone successfully accomplished this. Since that time, there have been reports of successful pulmonary embolectomy using this technique. This is a useful procedure when the cardiopulmonary bypass equipment is not available, but one has a working time of about two minutes in which to accomplish the embolectomy and restore the circulation. My own preference, and I think that of almost everyone now, is for the use of the cardiopulmonary bypass equipment.

In the young woman's case, as Doctor Hartz has mentioned, we heard about the patient and immediately asked the operating room and the pump technicians to set up the room for a pulmonary embolectomy, including priming the pump. At the time that we were contacted, we suspected that we had enough time to do at least a diagnostic procedure. We prefer pulmonary angiograph which can be done quickly and under optimal circumstances. Here, in a catheterization laboratory, any deterioration can be picked up quickly and treated expeditiously. In this institution, the catheterization laboratory is also immediately adjacent to the operating room. This is an added bonus and one which we felt would have made the trip worthwhile had we the time to do so.

Unfortunately, as we were loading the patient onto a stretcher to go to the cardiac catheterization laboratory, she suffered what was interpreted to be a cardiopulmonary arrest, although I suspect it was probably a further drop in her blood pressure which had been in the range of 40 to 50 systolic and then became unobtainable. Cardiopulmonary massage was instituted on the way to the operating room where we proceeded with an embolectomy.

Indications for Embolectomy

The indications for embolectomy are fairly clear. Most of the time, even with a large embolus, a patient can be brought around with external massage or with pressor drugs so that the need for embolectomy simply doesn't arise. We consider anyone with an embolus of sufficient magnitude to require pressor drugs for resuscitation a candidate for immediate caval interruption—not for embolectomy. A patient who requires pressor drugs for a massive pulmonary embolus—who has the embolus subsequently

proven by angiography and the cava interrupted—will usually resolve the clot and resume normal cardiopulmonary physiology in a few days.

A person who drops his vital signs and in whom pressor drugs *don't* restore satisfactory blood pressure, urine output, or mental status may well be a candidate for embolectomy. Usually, these patients are already on the move to the angiography suite to confirm the embolus and then to the operating room for caval plication. We are called about a potential embolectomy when pressor drugs begin to fail. A second indication is the much rarer situation of a patient who has chronic pulmonary arterial occlusion secondary to emboli weeks or months old. A delayed embolectomy can be performed, sometimes with satisfactory results. Secondary disability from an embolus makes this a consideration.

It is not common to encounter someone like our patient today who has a good clinical story for pulmonary emboli, but no diagnostic procedure performed to confirm it. It is our experience that emergency embolectomy done blindly, without an angiogram or some confirmatory data, sometimes confuses this picture with a myocardial infarction, a pneumothorax, septic shock, or some other catastrophe.

Additional Case Studies

This was a 30-year-old woman whose entire story was really classic, down to the electrocardiographic changes and a history of long-term birth control pill usage. Therefore, when she deteriorated, we elected to go directly to the operating room and hastily placed her on cardiopulmonary bypass. On opening the chest, the right ventricle bulged out of the chest. Although the pulmonary artery itself was not tense, there was very little contractile activity of the right ventricle; it was just barely quivering with each contraction. This explains why the physicians on the floor felt that she had had a cardiac arrest. This also bears out the point that Doctor Lesch brought up, that the pressure in the pulmonary artery is not necessarily high.

Once we had established cardiopulmonary bypass through the aortic arch and the vena cavae, the pulmonary artery was opened and the clot extracted from the left pulmonary artery, using a sucker with the tip removed. After the clot was removed, the pulmonary arteriotomy was closed and the patient allowed to take over on her own again. Severe right ventricular failure

can usually be treated pharmacologically, allowing the ventricle to recover over the next 24 hours.

In this patient, two pieces of clot about the same size were removed. In addition to the suction extraction, we also milk the lungs and pass a Fogarty catheter blindly into each lung in an effort to empty them as completely as possible.

Within the last 24 hours, we have had a similar patient, this time with a much more sudden event. One of the patients on the paraplegic service arrested with no story for any pre-disposing reason to do so. As a young man and a recent paraplegic, it was thought likely that he had had a pulmonary embolus, although he had had some seizure activity leading up to this which caused concern about the diagnosis. In his case, we used the portable cardiopulmonary bypass equipment that is available in the operating room. He was placed on cardiopulmonary bypass in the spinal cord unit and with this immediately resumed a relatively good cardiac rhythm, although his state of alertness never returned to normal. Under these circumstances, he was taken first to the angiography suite where Doctors Myers and Baressi were readily able to confirm the presence of a pulmonary embolus. Then, he was taken to the operating room, where a pulmonary embolectomy was performed with good return of cardiopulmonary activity.

Dr. John Beal: Dr. Paul Meyer, who is in charge of the Spinal Cord Injury Unit, has interesting information concerning the incidence of pulmonary embolus in this special unit.

Dr. Paul Meyer: The need for the program was emphasized yesterday with a pulmonary embolism in one of our spinal cord patients. In a paper just completed and presented at the 1977 American Academy of Orthopedic Surgeons, we reviewed a series of spinal cord patients having had an operative procedure known as the Weiss spring procedure. This is an internal fixation surgical procedure. Another group of patients had another surgical procedure, that of insertion of Harrington rods. The Weiss spring operative procedure is the insertion of Weiss springs as an internal fixation device on the lamina and posterior vertebral processes crossing the site of spinal fracture. Two patients of the 50 Weiss Spring procedures expired, one with an injury in the region of D-1 through D-6 and the other with an injury in the region of D-7 through D-12. One had surgery two weeks following injury and the other had surgery at three weeks following injury. Note that the deaths occurred at six

weeks and two weeks postoperatively. Both were victims of multiple trauma. One was an elderly gentleman, 68 years of age, who fell in his barn, apparently after a mild cerebral vascular accident. He fell from a hayloft, sustaining multiple rib fractures, as well as a fracture in the D-6 to D-7 area of his thoracic spine. He already had chronic pulmonary disease and required a tracheostomy for pulmonary function. He had severe gastrointestinal bleeding two weeks following surgery. He succumbed from a pulmonary embolism. The second patient was a 40-year-old man. He was a fireman teaching a group of scouts and fell 45 feet from a tree. He required splenectomy prior to transfer to Northwestern Memorial. He was found to have multiple rib fractures, a hemopneumothorax and a fracture dislocation of T11 on 12. He succumbed as a result of a pulmonary embolism.

We reviewed 50 spine injury cases with multiple trauma. Fourteen (28%) had multiple fractures; 6 (12%) had pulmonary embolism. Death occurred in 2 (4%), secondary to pulmonary embolism. Eight percent had hemopneumothoraces. Thrombophlebitis in this group was relatively low (4%).

A review of the world literature on conservative management of spinal cord injured patients demonstrates that there is a slightly higher incidence of complications in patients managed conservatively at prolonged bed rest. The incidence of pulmonary embolism by various authors is reported at between 15 and 30%. In the world literature, those patients operated upon and early mobilized (as has been our experience at Northwestern), pulmonary embolism rate is closer to 12 to 15%.

Associated Spinal Injury

Pulmonary embolism in the spinal injured patient most often occurs in the presence of multiple trauma. The patient who has two serious multiple traumas; i.e., multiple fractures and/or a ruptured spleen, falls into the category of two (or more) serious multiple injuries, other than spinal cord injury. This patient has a much higher incidence of pulmonary embolism than one who sustains only a fracture of the dorsal or lumbar spine. The patient under discussion at this conference today had a spinal fracture, multiple rib fractures, and a hemopneumothorax requiring initial treatment with a chest tube in a rural hospital. He was transferred to this institu-

tion after his chest tube had been removed and again was found to have had a hemopneumothorax, requiring reinsertion of a chest tube. I think this patient who also had a pulmonary embolism will likely succumb. He falls directly in line with the two patients just described—patients with multiple injuries who require prolonged bed rest, because of the serious nature of their multiple injuries.

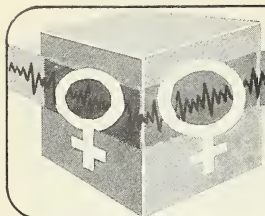
In subsequent conversation with Doctor Michaelis, the Spinal Cord Unit has elected to establish a standing policy that the cardiac arrest team and the thoracic vascular surgical staffs will be notified simultaneously when a massive life threatening pulmonary embolus is suspected. This should reduce the overall multi-service response time in life threatening cases.

Dr. James S. T. Yao: To comment on the two cases presented today: On the first case, I was called because they wanted to know the source of the emboli. In an emergency situation, the source of pulmonary emboli should be the last thing one would want to search for. This patient needed emergency cardiopulmonary support and an open heart team to perform an embolectomy as soon as possible. The patient should have gone to the cardiac catheterization laboratory for pulmonary angiogram and subsequent embolectomy rather than a lung scan, if the diagnosis was indeed an embolus.

Yesterday, I received a call on another patient. Again, the patient was being sent for a lung scan. I would like to emphasize that lung scan in this situation is absolutely useless. A pulmonary angiogram is needed. When a patient is in shock or in cardiac decompensation, a cardiac surgeon is needed to provide immediate cardiopulmonary support, as outlined by Doctor Sanders and subsequent pulmonary embolectomy.

On the second case, the non-invasive test was helpful, but when vena caval interruption is contemplated, one must perform a venogram. The contrast venogram would demonstrate the exact location of the thrombus or thrombi. In this case, if we went ahead and did a vena cava clipping, we might end up clipping a totally occluded vena cava. Venous thrombi, if non-occlusive and with a loose tail, are potentially dangerous and give rise to pulmonary embolism.

Dr. John Beal: I would like to point out that the tracings that Doctor Takaki presented came out of the Blood Flow Laboratory and we are indebted to Doctor Yao who has made those studies readily available for patients in the hospital. ◀



pulse... of the ISMS auxiliary

MRS. EUGENE VICKERY, Editor



KEY LINES:

BY BETTY SZEWCZYK, PRESIDENT, ISMSA

HELP, INC.

"A harbor, even if it is a little harbor, is a good thing, since adventures come into it as well as go out, and the life in it grows strong, because it takes something from the world and has something to give in return." (Jewett)

I can give you 6,163 reasons for belonging to Medical Auxiliary—that number is the amount of dollars ISMS Auxiliary contributed toward the Benevolence Fund last year.

The Benevolence Fund of the Illinois State Medical Society was founded in 1940 after Dr. John S. Nagel promoted the need for such a fund before the House of Delegates. The Society established the Medical Benevolence Fund and named Dr. Nagel chairman of a committee to plan and administer it.

In its earliest phase, the Medical Benevolence Fund was financed by appropriations from the ISMS treasury. Within a short time the task of raising money for the fund became a chief activity for the Auxiliary. Today, one dollar of each Auxiliary member's dues is contributed to Benevolence, plus other monies contributed by medical people in various projects.

Recently, the fund was incorporated as the Illinois State Medical Benevolent Fund, Inc. The purpose on the Certificate of Incorporation is

simply to help elderly and needy medical people who are in trouble financially—doctors, their families and widows in times of sickness, distress and death. The Corporation is organized and operated exclusively for charitable purposes. The Board of Directors consists of four members of the ISMS Finance Committee. For the past two years, the Auxiliary has been invited to have representation on the Benevolence Branch of the Finance Committee.

This fund has been sending monthly checks to an average of 30 physicians and/or their families since 1940. The amounts vary between \$100 and \$300 per month, depending upon the recipients' individual need, as reported annually. Needy cases should apply to the ISMS offices. All transactions and names are strictly confidential.

The history of this fund emphasizes the willingness of the medical profession to take care of its own members. (Society members contribute five dollars each from annual dues). The Auxiliary can be proud of the part it has played

in the achievements of this program. However, increased membership to our potential of 11,000 could mean almost \$5000 more for the Benevolence Fund.

This year's State Benevolence Chairman, Mrs. Alfred Faber, is eager to advise counties of the various means that are being utilized to raise

funds for this worthwhile program. Please write Ruth at 2110 Swainwood Drive, Glenview, Illinois, 60025, for information regarding memorial cards and other current money-raising ideas. If your county does not have a benevolence chairman, appointing one would be a good way to begin working for this cause.

Key Dates to Remember

September 15, District 12 Meeting, Mauh-Nah-Tee-Sec Country Club of Rockford

September 20, Districts 9 and 10, Holiday Inn, Mt. Vernon.

September 27, Districts 4 and 6, Quincy

October 6, Districts 5, 7 and 8, Champaign

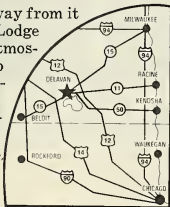
October 9-12, AMAA Leadership Confluence, Drake Hotel, Chicago

October 18, Districts 1, 2, 3, 11 Meeting and "Teach the Children" Conference, Holiday Inn South, Joliet

Members are invited to attend any and all of the meetings. You are particularly urged to participate in your own District Meeting and the "Teach the Children" Fall Conference in Joliet on October 18. Contact some auxiliary friends now and arrange for a group to attend. The programs will be tailored in response to your requests.

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Final classification of the less-than-effective indications requires further investigation.

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Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia. Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

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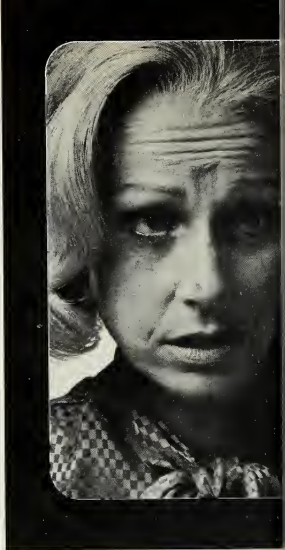
Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
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Clinics for Crippled Children Listed for October

Thirty-five clinics for Illinois' physically handicapped children have been scheduled for October by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-six general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination, along with medical social and nursing services. There will be seven special clinics for children with cardiac conditions and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- October 3 Peoria Cardiac, St. Francis Hospital
- October 4 E. St. Louis, Christian Welfare Hospital
- October 4 Quincy, Blessing Hospital
- October 4 Metropolis, Massac Memorial Hospital
- October 5 Cairo, Public Health Department
- October 5 Hinsdale, Hinsdale Sanitarium
- October 6 Sterling, Community General Hospital
- October 6 Flora, Clay County Hospital
- October 6 Lake County Cardiac, Victory Memorial Hospital
- October 7 Division Cardiac, U. of I. at the Medical Center
- October 11 Peoria, St. Francis Hospital
- October 12 Champaign-Urbana, McKinley Hospital
- October 12 Joliet, St. Joseph's Hospital
- October 13 Springfield, St. John's Hospital
- October 13 Kankakee, St. Mary's Hospital
- October 14 Chicago Heights Cardiac, St. James Hospital
- October 17 Maywood, Loyola Medical Center
- October 18 Belleville, St. Elizabeth's Hospital
- October 18 Rock Island, Moline Public Hospital
- October 18 Decatur, Decatur Memorial
- October 19 Springfield Pediatric-Neurology, St. John's Hospital
- October 19 Centralia, St. Mary's Hospital
- October 19 Chicago Heights General-St. James Hospital
- October 20 Rockford, St. Anthony's Hospital
- October 20 Bloomington, Mennonite Hospital
- October 20 Elmhurst Cardiac, Memorial Hospital of DuPage County
- October 24 Peoria Cardiac, St. Francis Hospital
- October 25 Peoria, St. Francis Hospital
- October 25 Danville, Lake View Hospital
- October 25 Park Ridge Cardiac, Lutheran General Hospital
- October 26 Jacksonville, Passavant Hospital
- October 26 Mt. Vernon, Good Samaritan Hospital
- October 26 Aurora, St. Joseph Mercy Hospital
- October 28 Evanston, St. Francis Hospital
- October 28 Chicago Heights Cardiac, St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local, social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.



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PRECAUTIONS: As with other effective nitrites some fall in blood pressure may occur with large doses.

Caution should be observed in administering this drug to patients with a history of recent cerebral hemorrhage, because of the vasodilation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS: No serious side effects have been reported. In sublingual therapy, a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

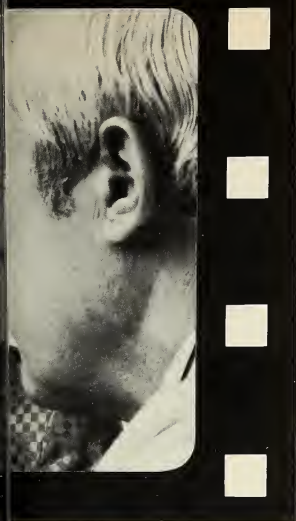
Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

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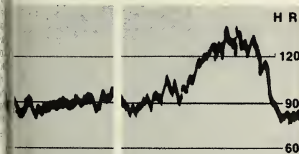
Sex and the heart patient:

A film every doctor should see.

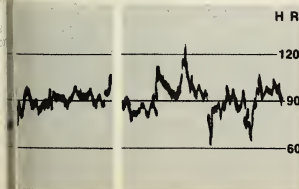
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Obituaries

*Cloninger, Samuel R., Wilmette, died July 26 at the age of 49. Doctor Cloninger was a 1954 graduate of Northwestern University.

**Deutsch, Emil, Chicago, died July 22 at the age of 85. Doctor Deutsch was a 1917 graduate of Illinois Medical College in Chicago.

*France, John T., Bloomington, died July 21 at the age of 67. Doctor France was a 1933 Loyola graduate.

*Janson, Herbert, Homewood, died July 23 at the age of 69. Doctor Janson was a 1935 graduate of Rush Medical College.

**Johnson, Mabel R., Carlson, Blue Island, died August first at the age of 88. Doctor Johnson was a 1912 graduate of the University of Illinois.

*Kaminski, Paul J., Fort Meyers, Florida, died June 30th at the age of 63. Formerly of Danville, Doctor Kaminski was a 1939 graduate of John Hopkins University.

**Kraft, Sigurd H., Ft. Lauderdale, Florida, died July 25 at the age of 88. A Chicago native, Doctor Kraft was a 1912 graduate of the University of Illinois.

*Necheles, Henrietta, Chicago, died July 28 at the age of 79. Doctor Necheles was a 1923 graduate of the University of Baden-Wurtemberg, Germany.

*Schlageter, Charles, Evanston, died July 16 at the age of 57. Doctor Schlageter graduated from the University of Chicago Medical School and was board certified in 1951. Recently elected Secretary of the Chicago Medical Society, Doctor Schlageter had held several posts with ISMS and the Illinois Psychiatric Society.

Washburn, Richard N., Elmhurst, died July 28 at the age of 69. Doctor Washburn was a 1935 graduate of the University of Illinois.

*Indicates ISMS member.

**Indicates member of the ISMS Fifty Year Club.

ISMS Travel Program

The following ISMS sponsored travel programs have been scheduled for 1978:

January 3-12—*West Indies Air/Sea Cruise* (Leeward & Windward Islands)

March 2-10—*South America—Quito & Lima* (Optional tour of Galapagos Islands)

May 5-19—*Egypt-Greek Isles* (6 days Cairo—6 days Greek Isles Cruise).

July 6-20—*Scandinavia*—(Stockholm, Helsinki, & Copenhagen—Optional tour to Leningrad)

Sept. 5-19—*Imperial Europe* (Vienna, Budapest & Dubrovnik)

Nov. 1-14—*Eastern Mediterranean Air/Sea Cruise* (Greek Isles, Turkey, Egypt, & Israel)

Descriptive brochures will be mailed five months in advance. Reservations cannot be accepted without the official form printed in these brochures. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. *Promotional expenses connected with these programs are paid for by the tour operator.* For further information, contact Perry Smithers or Betty Duffy at ISMS headquarters.

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Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

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December 4, 1977

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GENESE0: Physicians wanted for Family Practice, OB-Gyn, Pediatrics, Internal Medicine, General and Orthopedic Surgery. Attractive, prosperous, residential community of over 7,000; serving trade area of 35,000 population. Located on Interstate 80, 2½ hours from Chicago; 25 miles east of Quad Cities metropolitan area of 350,000. Ideal, safe, small city living with excellent recreational facilities. New ultra modern hospital with 110 beds. New modern doctor's offices and housing on hospital property immediately available. Attractive financial arrangements include guarantee. Contact Physician Recruitment Committee, 210 W. Elk St., Geneseo, 61254 or phone collect; G. L. Wissink, Administrator (309) 944-6431. (10)

LaSALLE-PERU: Board certified or eligible anesthesiologists to head department in North-Central Illinois hospital serving 35,000 area population. Four CRNA's currently on staff. Located two hours from Chicago, this area offers recreational facilities, good schools and housing. Contact W. T. Schweickert, Administrator, 925 West St., Peru, 61354. 815-223-3300. (10)

MACOMB: Western Illinois University—Seeking Director University Health Service. Present enrollment 14,000. Director is Chief Administrative Health Officer supervising nursing and para-medical staff in modern health facility. Forty-hour work week; paid vacation; sick leave; hospitalization insurance; excellent retirement program. Contact V.P. Student Affairs, Western Illinois University, Macomb 61455. An Equal Opportunity Employer. Phone 309-298-1814. (10)

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PEORIA: Immediate full time position open for career minded physician in progressive 550 bed hospital. Opportunity to practice Emergency Medicine in busy emergency department seeing 26,000 visits as well as teach medical students and Family Practice residents. Work 16 or 24 hour shifts with excellent specialty back up. Compensation above average with flexible scheduling. Enjoy a dynamic, friendly community of 250,000 in central Illinois. Forward curriculum vitae or contact H. Stratton, M.D., Methodist Medical Center of Illinois, 221 N.E. Glen Oak, Peoria 61636, at 309 672-5500 or 309-691-7410. (10)

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SULLIVAN: A new \$1,000,000 medical facility is looking for doctors in a midstate town of 4,000. It offers challenging positions for creative individuals to design and implement patient-care programs. Partnerships

with established doctors also available. Three hospitals are within thirty miles. An 11,000 acre recreational lake is nearby. Contact: Bob Lemler, 200 S. Hamilton, Sullivan, 61951. 217-728-4311. (10)

TUSCOLA: Internist needed. Excellent hospital facilities. Located twenty miles from Champaign-Urbana and the University of Illinois campus. Financial assistance, office facilities available. Contact Norm Rentz, 704 N. Main St., Tuscola, 61953. (217) 253-3361. (10)

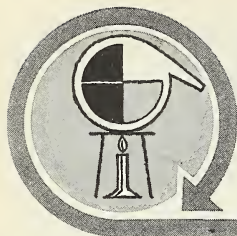
WHITE HALL: Area population 12,000. Family Practitioners, Internist and Pediatrician needed. 30 bed hospital, expansion in process. 2 Physicians. Excellent schools, recreation and housing. Contact Larry Bear, White Hall Hospital, White Hall 62092. (217) 374-2121. (10)

EKG

(Continued from page 167)

Answers: 1. A,B,C. 2. A,D.

The first three beats of the V1-V2-V3 rhythm strip are paced beats, although the third is a fusion beat. The fourth beat shows the QRS of complete right bundle branch block. The fourth pacemaker spike (best seen in lead V3) fires in the T wave of the preceding beat and is non-conducted. The pacemaker failed to sense this atrial capture beat and suppress appropriately. The 6th, 7th, 8th, and 9th beats are atrial capture beats from atrial fibrillation with a slow ventricular rate. The 10th beat is a pacemaker capture beat which comes prematurely and captures the ventricles. Once again the demand mode of the pacemaker failed to suppress the pacer and it fired in competition with the patient's spontaneous rhythm. The pacemaker as well as the temporary pacing catheter were examined. The pacemaker was replaced and the catheter repositioned. Atrial fibrillation with a high grade atrioventricular block and a slow ventricular response due to a junctional escape rhythm can be caused by digitalis excess. If digitalis excess is suspected, it would be prudent to hold the medication and observe the patient. In our patient this allowed an increase in his heart rate but only to approximately 70 beats/minute. His heart failure worsened and was not caused by his moderate mitral regurgitation. Thus, in our patient congestive heart failure was complicated by atrial fibrillation and a slow ventricular rate. Eventually, both a permanent pacemaker and digitalis were required.



new pharmaceutical specialties

By PAUL DEHAEN

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

New Single Drugs—Drugs not previously known, including new salts.

Duplicate Single Drugs—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

NEW SINGLE DRUGS

COLESTID Cholesterol Reducing Agent Rx
 Manufacturer: The Upjohn Company
 Indications: High cholesterol plasma levels
 Caution: Do not take in dry form
 Dosage: 10 g b.i.d. in a liquid
 Supplied: Packets, 5 g

DUPLICATE SINGLE DRUGS

UTICORT Gel Local Corticoid Rx
 Manufacturer: Parke-Davis
 Nonproprietary Name: Betamethasone benzoate
 Indications: Inflammatory manifestations of corticosteroid-responsive dermatoses
 Administration: Apply 2 to 4 times daily to affected areas
 Supplied: Tubes, 15 and 60 g, 0.025%

DUPLICATE SINGLE DRUGS

LIDONE Psychotropic Rx
 Manufacturer: Abbott Laboratories
 Nonproprietary Name: Molindone HCl
 Indications: Management of manifestations of schizophrenia
 Contraindications: Severe central nervous system depressions
 Dosage: Follow package instructions
 Supplied: Capsules, 5, 10 and 25 mg

NEW DOSAGE FORMS

ISORDIL Coronary Vasodilator Rx
Chewable Tablets
 Manufacturer: Ives Laboratories
 Nonproprietary Name: Isosorbide dinitrate
 Indications: Acute anginal attacks
 Dosage: Adjust to requirement of patient
 Supplied: Chewable tablets, 10 mg

LASIX Oral Solution Diuretic and Antihypertensive Rx
 Manufacturer: Hoechst-Roussel Pharmaceuticals, Inc.
 Nonproprietary Name: Furosemide
 Indications: Congestive heart failure with edema and hypertension
 Adults—edema single dose, 20 to 80 mg
 hypertension, 40 mg b.i.d.
 Infants and children, 2 mg/kg body weight, single dose
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Some Demographic Characteristics of a Psychiatric Inpatient Unit in an Urban General Hospital

BY JOHN W. LAUER, M.D./CHICAGO

The number of psychiatric units in general hospitals has increased significantly in the United States over the past two decades. This study attempts to answer the following questions: Who comes to such a unit; what is done for him, how long does he stay, and where does he go when he leaves?

The 1,699 records of patients admitted to the new psychiatric unit of the Chicago Wesley Memorial Hospital from 1961 through 1966 were examined. These records covered the first five years the unit was fully operative.

Concise record forms that include all pertinent information for each patient must be devised and adopted. To complete these forms accurately and precisely, much cooperation and conscientious work is required from staff members. For such records to be useful in research, statistical studies of epidemiology and medical ecology, and the evaluation and classification of treatments and facilities, agreement on nosological entities is essential.

The psychiatric unit as an integral part of a general hospital has significantly influenced the manner in which psychiatric care is made available to mentally ill patients in the United States. These units provide short-term hospital care for private psychiatric patients. Their numbers have continued to increase because of the trend toward caring for patients in their communities rather than in an institution exclusively for the mentally ill.¹⁻⁶

During the 18th century, the Philadelphia General Hospital was the first general hospital in the United States to open a psychiatric unit. During the mid-19th century, psychiatric patients were admitted and treated at the Jews' Hospital, now the Mount Sinai Hospital of New York, one of the first voluntary general hospitals to serve these patients.⁷ The Henry Ford Hospi-

tal in Detroit established a psychiatric unit in 1924.⁸ Despite these early beginnings, it is only in the past 20 years that psychiatric units have increased markedly and become sufficiently widespread to exert a significant impact on the care of mentally ill patients in the United States.⁹

In 1954 only 10% of United States general hospitals admitted psychiatric patients, but these hospitals accounted for over half of all first psychiatric admissions throughout the country.¹⁰

Psychiatric admissions in 1958 totalled 265,730 against 210,117 patients in the public mental hospitals. This represented a 27% increase in psychiatric admissions to general hospitals since 1954. During the same four year period the number of general hospitals accepting psychiatric patients rose 41%.¹¹ By 1961, there were 621 mental hospitals in the United States, and 789 psychiatric sections in general hospitals. Evidence now shows that practically all psychiatric patients can be treated in a psychiatric unit in a general hospital.¹²

The establishment of such psychiatric units holds many implications for the future of mental

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health care. In order to most productively channel this development we must analyze these implications.

Significant legislation has been enacted including the Community Mental Health Centers Act of 1963, and the Community Mental Health Centers Act Amendment of 1965. To implement these laws and develop and modify state plans, considerable data is needed. Information on the distribution of mental illnesses, and the existing patterns of utilization of psychiatric services by patients according to their age, sex, socioeconomic group, and diagnosis is pertinent.¹³

Background Information

The aim of this paper is to describe some demographic characteristics of the population of a psychiatric unit in a general hospital, the Chicago Wesley Memorial Hospital, during the first five years that the unit was fully operative (1961-1966). Improvement of our present system of keeping patient records to ensure that precise and meaningful data on the effectiveness of various treatment modalities, and therapeutic and rehabilitation programs for patients with specific characteristics, can be made available. This aim can be achieved only when there is general agreement on nosological entities and when accurate diagnoses and classifications of patients are made and faithfully recorded.¹³

Chicago Wesley Memorial Hospital* was a 750-bed general hospital located about a mile from the heart of Chicago's downtown district. The area has luxurious apartments, mansions, and hotels for people in high income brackets juxtaposed against dilapidated housing and cheap transient hotels, within a radius of one or two miles. Although patients came to Wesley from all over the city and state, it seemed reasonable to expect that its location would have a bearing on the socioeconomic status (particularly emergency admissions) of the patient population.

The psychiatric unit consisted of two wards with a total of 50 beds on 5 North of the Wesley Memorial Hospital complex. Of the two wards, 5 Northwest was used for the more disturbed patients while 5 Northeast was used for persons having milder psychiatric disorders. One bed on

each ward was reserved for emergency transfers within the hospital. Admission to either of the units was by reservation (as it had been arbitrarily decided that there would be no emergency admissions from outside the hospital). Such emergency patients were treated in one of the following ways:

1. Kept at home with their families;
2. Put on a medical ward in the hospital with special nurses around the clock;
3. Hospitalized temporarily at another facility until a bed became available in the Wesley psychiatric unit; or
4. Referred to another psychiatrist at a hospital with an available bed.

Occasionally both emergency beds were in use, and another emergency occurred in a medical, surgical, or other ward in the hospital. The case was then treated as an emergency brought in from outside with special nurses around the clock, until one of the emergency beds became available. When the emergency beds were not being used by a patient transferred from within the hospital, they remained empty regardless of the length of the waiting list of people for the units.

The Northeast unit was run as an open ward, and no adverse incidents were experienced during the time of this study. In practice, the attending psychiatrist issued passes to the patients at his discretion. These passes usually specified an area of two square blocks outside the hospital, but sometimes they were limited to the hospital, (but off the psychiatric ward). At the discretion of the physician, passes sometimes indicated the patient was to be "with staff" or "with family."

The ward on 5 Northeast was also a day hospital for psychiatric patients from other areas of the hospital.

From the time the new psychiatric unit was instituted at Wesley on May 30, 1959, as many beds were filled as the nursing staff could tend. The facilities could not be fully utilized because of shortages of nursing staff, and the census of the unit did not reach full complement until the beginning of 1962.

This study begins with 1961, but only the five years of 1962 through 1966 can be considered representative of the fully operative unit.

Methods and Procedures

This study is based upon the information gathered from 1,699 patient records from the period beginning in 1961 and continuing through the end of 1966. These records consist of State of

*Chicago Wesley Memorial Hospital was combined with Passavant Hospital, a neighboring 378-bed hospital on September 1, 1972, and renamed the Northwestern Memorial Hospital. NMH is currently (1976) a 1222-bed hospital, and the Institute of Psychiatry now serves the combined facility. The author has suggested that a comparable analysis of data 1972-76, reflecting the effects of this merger, would be an interesting study.

Table 1
Age Distribution of Patients at Time of Admission

	1961	1962	1963	1964	1965	1966	1961 thru 1966	
							Total	Percent
4-12 yrs.	0	0	2	3	0	3	8	0.5
12-21 yrs.	5	30	24	26	33	28	146	8.5
21-29 yrs.	5	30	44	44	33	39	195	11.5
29-38 yrs.	7	37	52	57	37	32	222	13.0
38-46 yrs.	5	47	53	44	43	49	241	14.2
46-54 yrs.	9	63	58	66	66	68	330	19.4
54-63 yrs.	4	40	57	51	46	35	233	13.8
63-71 yrs.	6	45	47	46	38	48	230	13.5
71-80 yrs.	0	10	16	14	15	17	72	4.3
80-88 yrs.	0	4	2	2	8	4	20	1.2
88-96 yrs.	0	1	0	0	0	0	1	0.06
Total—all ages	41	307	355	353	319	323	1,698	100.0

Table 2
Number of Male and Female Patients Admitted and Readmitted

	First Admissions			Readmissions to Wesley			All Admissions		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
1961	7	13	20	7	14	21	14	27	41
1962	69	92	161	49	97	146	118	189	307
1963	59	133	192	50	113	163	109	246	355
1964	60	129	189	64	100	164	124	229	353
1965	60	114	174	47	98	145	107	212	319
1966	74	118	192	38	90	128	112	208	320
Total	329	599	928	255	512	767	584	1,111	1,695
Percent	55			45			34.5	65.5	100

Illinois Department of Mental Health admission and separation forms. Such records were kept for each patient from the time the psychiatric unit was instituted. Using the information from these records, the data were analyzed to determine the demographic characteristics of the patients on the unit, what was done for the patients, how long they stayed, and where they went after they were treated and discharged.

Findings and Discussion

Population

During the first five years of full operation the psychiatric unit at Wesley admitted an average of 332 patients each year. Fifty beds were available in the two units; this was an average of 6.6 patients per bed per year. A total of 1,658 patients were admitted during the first five years. The carry-over from 1961, before the unit was operating at capacity, totalled 41 additional patients.

Age:

The mean age of the patients at the time of

admission was between 46 and 54 years; over 19% were in this age group. The numbers of patients were distributed evenly on either side of the mean, except for a sharp drop-off at about age 71 (as expected in any population) due to deaths. Table 1 shows the number of patients in each age group for each year.

Race

Ninety-seven percent of the patients admitted to the psychiatric unit at Wesley were caucasian; 2 percent were black, and the remaining 1 percent were of oriental and other races.

Admissions and Readmissions

The study found a relatively high rate of recidivism. Once the unit had become established, 45% of the men and women admitted had been treated there before and 55% of the patients were initial admissions. Table 2 shows the number of male and female patients admitted and readmitted each year. The women consistently outnumbered the men in both categories. The overall rate of admissions for women was almost double the admission rate for men. Other in-

Table 3

	Marital Status of Patients At Time of Admission						Total
	Never Married	Married	Widowed	Divorced	Separated	Undetermined	
1961	14	21	3	3	0	0	41
1962	96	176	22	11	2	0	307
1963	74	228	33	18	1	1	355
1964	94	210	28	17	1	3	353
1965	85	178	35	21	0	0	319
1966	98	168	34	12	4	4	320
Total	461	981	155	82	8	8	1,695
Percent	27	58	9	5	0.5	0.5	100

vestigators have reported similarly high admission ratios of women to men.^{8,9,14}

Private and Welfare Cases

Ninety-seven percent of the patients were private while only three percent were services cases.

Religion

Forty-two percent of the patients were Protestant; 31% were Catholic; and 15% of the patients were Hebrew. The patient's religion could not be ascertained in 3% of the cases; 3.5% indicated that they had no religion.

Marital Status

The majority of the patients, 58%, were married. In contradistinction to other studies which generally report that the unmarried individuals comprise the larger group of hospitalized mental patients, only 27% of the patients admitted to the psychiatric unit at Wesley during the period of this study had never been married. Table 3 showed the number of patients in each marital category for each year.

Table 4 correlates the marital status of patients with first admission and readmission rates. First admission rates were generally higher than readmission rates regardless of the patient's marital status with one exception: among the widowed, the readmission rate was almost double that of first admissions. Among the patients who were never married, the rate of first admissions

was almost double that of readmissions.

In the married, widowed, divorced, and undetermined categories, women outnumbered men, but in the group that never married, women comprise only a slight majority. Among those that had been separated, the men outnumbered the women. This may lend support to the women's liberationist view that marriage is more advantageous for men than for women as far as mental health is concerned.

Prior Psychiatric Care

Only half the patients admitted, 51%, had never before been in any institution for the mentally ill. Forty-two percent had been seen before in the psychiatric unit at Wesley, and the remaining 7% had been admitted previously to some other psychiatric institution.

Diagnosis

Diagnoses were recorded for 1,324 of the 1,699 patients in this study. The largest number of patients for whom this datum was recorded, 30%, were diagnosed as psychoneurotic, with the second largest number, 26%, diagnosed as schizophrenic. Psychophysiological reactions and personality disorders each accounted for 11% of the diagnoses; non-organic illnesses accounted for another 10%. Chronic brain syndrome accounted for 8% of the recorded diagnoses and the single most frequent known cause was trauma. Acute

Table 4
Patients' Marital Status Correlated With Type of Admission
Admission Type

Marital Status	First Admission				Readmission				Total
	Male	Female	Total	Percent	Male	Female	Total	Percent	
Never Married	126	174	300	65.1	67	94	161	34.9	461
Married	182	330	512	52.3	175	292	467	47.7	979
Widowed	7	49	56	36.1	6	93	99	63.9	155
Divorced	9	39	48	59.3	5	28	33	40.7	81
Separated	4	1	5	62.5	2	1	3	37.5	8
Undetermined Status	1	4	5	71.4	0	2	2	28.6	7
Total	329	597	926	54.8	255	510	765	45.2	1,691

Table 5

Diagnoses

Diagnostic Categories	Number of Patients						Total	Percent
	1961	1962	1963	1964	1965	1966		
Major Psychoses:								
Schizophrenia	19	92		99	65	66	341	26.0
Manic Depressive Illness	2	41		25	9	19	96	7.3
Other Psychotic Disorders:								
Involuntal Melancholia	1	18		13	2	5	39	
Involuntal Paranoia	0	0		0	1	2	3	
Unspecified Psychosis	0	0		0	1	0	1	
Total Other Psychotic Disorders	1	18		13	4	7	43	3.2
Neuroses	11	89		82	103	107	392	29.5
Psychophysiologic Disorders	1	35		34	25	46	141	10.5
Personality Disorders	4	23		32	26	27	112	8.5
Sociopathic Personality Disturbances	0	1		6	6	4	17	1.3
Transient Situational Disturbance	0	3		4	1	7	15	1.1
Mental Retardation	0	1		1	0	2	4	0.3
Acute Brain Syndrome:								
Infection	0	0		1	0	0	1	
Intoxication	1	8		6	6	6	27	
Trauma	0	2		2	1	0	5	
Circulatory disease	0	0		2	0	1	3	
Convulsive disease	0	1		1	0	0	2	
Metabolic disturbance	0	1		0	0	1	2	
Intracranial neoplasm	0	0		1	0	2	3	
With disease of unknown cause	0	0		2	1	4	7	
Total Acute Brain Syndrome	1	12		15	8	14	50	3.8
Chronic Brain Syndrome:								
With disease due to prenatal influence	0	0		0	0	1	1	
With CNS syphilis	0	1		1	0	0	2	
Encephalitis	0	5		4	3	0	12	
Intoxication	0	0		2	1	0	3	
Trauma	1	12		6	9	5	33	
Circulatory disturbance	0	0		1	2	0	3	
Convulsive disease	0	4		6	5	0	15	
Metabolic disturbance	0	2		1	3	1	7	
Tumor	1	0		0	0	1	2	
Unknown cause	0	8		10	9	8	35	
Total Chronic Brain Syndrome	2	32		31	32	16	113	8.5

brain syndrome accounted for 4% of the diagnoses; intoxication was the most frequent cause for this diagnosis. Table 5 lists the number of patients in each diagnostic category. Information concerning diagnoses was not available for 1963.

Treatment Modalities

Drugs were the principal treatment modality for over one-third of the patients (34%). An additional 25% received medications as an adjunct to other treatment: 9.5% received electroconvulsive therapy along with the drugs; 15.4% received electro-shock treatment and psychotherapy along with medications. Forty-two percent were given electro-shock therapy. Six percent received only electro-shock therapy and 36%

had it in combination with other treatments. Eight percent were treated with insulin. Two percent had insulin treatment alone and 6% had it in combination with other modalities. Twenty-two percent were treated with psychotherapy: alone (6%) or in combination with other therapies (16%). Eight percent of the patients were given no treatment at all. Table 6 shows the numbers of patients receiving the various treatments and combinations of treatments during each year.

Length of Stay

Eighteen percent of the patients admitted to the Chicago Wesley Memorial psychiatric unit left within ten days. Almost half of the patients

Table 6
Treatments Given

	1961	1962	1963	1964	1965	1966	Total	Percent
Electro shock	2	20	17	5	3	2	49	6
Insulin	0	6	5	2	0	0	13	2
Medications	5	33	55	59	37	68	257	34
Psychotherapy	1	17	14	8	4	0	44	6
Other	2	14	13	16	2	12	59	8
None	0	14	13	11	2	19	59	8
Electro shock + insulin	0	1	1	0	0	0	2	3
Electro shock + medications	0	6	31	8	11	16	72	10
Electro shock + psychotherapy	2	5	1	1	0	0	9	1
Electro shock + other	11	25	14	2	1	0	53	7
Insulin + psychotherapy	0	4	1	5	0	1	11	1
Insulin + other	2	8	4	2	0	0	16	2
Electro shock + drugs + psychotherapy	2	19	23	26	37	10	117	15
Total	27	172	192	145	97	128	761	103

(44.8%) were discharged within 30 days. Seventy percent were discharged within 50 days. Nine percent remained over 100 days.

There was little difference between the length of stay of men compared to women, or between first admissions and readmissions.

Type of Separation

The great majority of patients treated in the psychiatric unit at Chicago Wesley Memorial, 74%, returned to their communities with the approval of their psychiatrist. Five percent returned to their communities against advice. Another 5% were released to the care of another (local) private psychiatrist; some of these patients may have been from down-state Illinois and would necessarily have been released to a doctor other than their Wesley physician. Another 5% were transferred to a general ward at Wesley. About 3% became outpatients either at the Northwestern University Medical School Clinic or at another psychiatric clinic. Less than 3% were trans-

ferred to the state mental hospital, and less than 1% died. Table 7 reveals the details of the manner in which the patients were separated from the psychiatric unit at Chicago Wesley Memorial for each year of the study.

The Typical Patient

Based upon our analysis of the records described in this paper, a typical patient at the Chicago Wesley Memorial Hospital psychiatric unit was a married caucasian protestant woman between 46 and 54 years of age. She probably was psychoneurotic, but possibly schizophrenic, and was admitted as a private patient. She had never been admitted previously to the CWMH unit or to any other institution for psychiatric care. Her treatment consisted of drug therapy, and after a stay of 10 days or less, she was released to her community with the approval of her CWMH psychiatrist.

Table 7
Type of Separation of Patient from the Unit

	1961	1962	1963	1964	1965	1966	Total	Percent
To community with approval	34	239	262	205	197	184	1,121	74.0
To community against advice	0	12	16	19	16	16	79	5.5
To Wesley outpatient psychiatric care clinic	0	1	17	9	2	0	29	2.0
To any other outpatient psychiatric care clinic	1	2	3	6	0	2	14	0.9
To Wesley general ward	0	9	9	20	17	22	77	5.3
To other general hospital general ward	0	1	1	0	1	2	5	0.3
To State mental hospital	2	12	10	7	7	4	42	2.8
To private sanitarium for mentally ill	1	14	12	7	10	4	48	3.2
To private psychiatrist	3	16	24	26	17	15	103	5.5
Death	0	0	1	5	3	2	11	0.8
Total	41	306	355	304	270	251	1,529	100

It is interesting that despite the location of CWMH near an urban renewal area where we might expect patients from lower socioeconomic levels, the typical patient was a member of the "establishment." This may be explained in part by the severely limited state and federal government funding which permitted only a very few free-bed patients to come to the hospital.

Importance of the Record Form and Record-keeping Tasks

Unfortunately, the records upon which this study is based are incomplete. For example, the base number of patients for the year 1966 varies in the tables from 264 to 324, depending on the particular data consulted. The number of patients previously admitted to the CWMH unit is 45%, according to Table 2 which compares first admissions and readmissions based on 1,695 patient records, but it is only 42% according to a second tabulation which shows prior psychiatric care, based on 1,471 patient records. The diagnoses for all patients throughout 1963 is unavailable.

There is an urgent need for consistent, valid information about psychiatric patients. Precise and accurate records are the foundation of any

evaluation of effectiveness of the sundry treatments applied to patients with variously diagnosed mental disorders, and are of great value in pointing the direction for future research. Good records are useful in epidemiology and medical ecology. Medical care statistics depend on the existence of such records to classify types of facilities and treatments.

Diagnostic and demographic data obtainable from psychiatric facilities will be used increasingly for research purposes, program planning, and for various administrative, clinical, epidemiological, and other studies.¹²

It seems obvious that agreement on nosological entities is essential. To facilitate record-keeping, information sheets must be devised to include and make available all pertinent information regarding each patient. Such forms must be complete and thorough, yet manageable. At the same time, much cooperation is needed from staff and personnel in conscientiously completing the information forms that are provided. ◀

References and Reprints

A complete set of references for "Some Demographic Characteristics of a Psychiatric Inpatient Unit in an Urban General Hospital" may be obtained by writing the author at 251 E. Chicago Avenue, Suite 1427, Chicago, IL 60611. Further data and reprints also may be obtained.

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(Continued from page 172)

DIAGNOSIS: Bilateral renal cysts—

Typically extensive lymphoproliferative disorders involving the retroperitoneum should cause anterior displacement of the aorta. The aorta in Figure 1B is in normal position. Space occupying masses of the liver should not cause anterior displacement of the second portion of the duodenum.¹ Pseudocyst of the pancreas may mimic any disease process and may present as two separate masses. However, the clinical history and laboratory test do not lend support to this diagnosis. The antero-medial displacement of the second portion of the duodenum is fairly characteristic of renal masses.

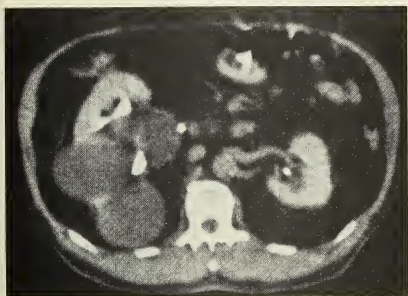


Figure 3A

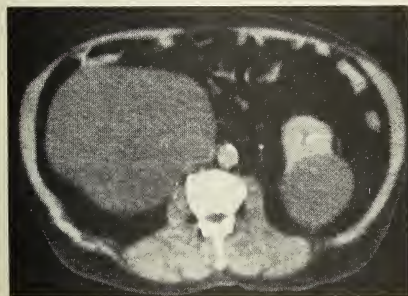


Figure 3B

The IVP demonstrated bilateral renal masses most likely cystic. A CT examination was performed because of the right kidney's bizarre appearance. The CAT scan clearly demonstrates the well defined masses of water density which did not enhance with contrast infusion (Figures 3A and 3B). These findings are diagnostic of bilateral renal cysts.²

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The Posterior Interosseous Nerve Syndrome

BY LOUIS W. KOLB, M.D., F.A.C.S./CHICAGO

The syndrome of posterior interosseous nerve compression at the region of the elbow seen in rheumatoid arthritis is presented along with its clinical features. The condition can be an unusual cause of inability to extend the fingers. It can mimic the peripheral manifestations of rheumatoid cervical spondylitis as well as the more common extensor tendon ruptures about the wrist seen in rheumatoid arthritis. Differential diagnostic testing as well as therapy are discussed.

Rheumatoid arthritis can be considered a disease of unknown etiology clinically manifested by a hypertrophic synovium that is usually polyarticular in distribution. This condition, however, frequently demonstrates extra-articular abnormalities. These may include tendon ruptures, as well as subluxation or even frank dislocation of the cervical spine, presenting with neurological abnormalities. Peripheral entrapment neuropathies are also known to occur in rheumatoid arthritis, perhaps most commonly median nerve compression at the wrist (the carpal-tunnel syndrome).

The purpose of this paper is to point out and describe a decidedly less common peripheral entrapment neuropathy seen in rheumatoid arthritis—that of the posterior interosseous nerve. It can closely mimic cervical radiculopathy secondary to rheumatoid involvement or extensor tendon ruptures at the wrist associated with this disease. These conditions require different therapy and proper diagnosis is essential. Tests which can be performed in the office as well as more sophisticated testing will be described to aid in

this differential diagnosis.

The author does not purport to describe a new entity. However, this condition has heretofore been reported only in the orthopaedic literature and it would seem worthwhile to alert the primary physician to its existence.

Clinical Features

Entrapment of the posterior interosseous (deep branch of the radial) nerve is characterized by a painless inability to actively extend the fingers and thumb. It may be of sudden or insidious onset and is not associated with any demonstrable sensory deficit.

The posterior interosseous nerve is one of two terminal branches of the radial nerve. It innervates the muscles which dorsiflex the wrist and fingers. The other terminal branch of the radial nerve, the superficial radial nerve, innervates the skin over the radial side of the dorsum of the wrist and hand and terminates in the dorsal digital nerves. These carry sensation from the dorsal surface of the radial three and one-half digits. These two terminal branches are formed by a bifurcation of the main radial nerve slightly above the elbow at its outer side. Following bifurcation, the posterior interosseous nerve passes under the fibrous edge of the extensor carpi radialis and through a slit in the supinator muscle. An articular branch is given off at this point, but it can be ignored for the purpose of present discussion.

The posterior interosseous nerve then travels anterior to the radial head and through the body



LOUIS W. KOLB, M.D., F.A.C.S., is an attending surgeon in the section of orthopaedic surgery at Illinois Masonic Medical Center in Chicago. A former associate professor in orthopaedic surgery for the University of Chicago Hospitals and Clinics, Doctor Kolb was regional admissions committee chairman for the American Academy of Orthopaedic Surgery and is a Fellow of the American College of Surgeons.

of the supinator to gain entrance to the forearm's posterior aspect. Contact with the interosseous membrane gives it the name of the posterior interosseous nerve. The nerve terminates in a gangliform enlargement at the dorsal aspect of the carpus, and its deep branch supplies forearm extensor musculature. The radial nerve's superficial branch generally passes over the extensor carpi radialis brevis and runs down the forearm beneath the brachioradialis.¹

Due to the proximity of the posterior interosseous nerve to the elbow, any distention of this joint capsule as may be seen secondary to the hypertrophic synovitis in rheumatoid arthritis can cause the nerve to compress and interrupt impulse transmission to the muscles it innervates. The patient will present with a painless inability to extend fingers and thumb actively, yet will exhibit sensation over the dorsum of the hand. This will help to distinguish this condition from a radiculopathy seen in cervical spondylitis where a searching examination usually reveals sensory loss. Additionally, common extensor tendon ruptures at the wrist secondary to structural attrition (due to rheumatoid arthritis or distal radioulnar subluxation) demonstrate incongruity of the involved tendons. This is in contradistinction to inability to extend fingers as seen in posterior interosseous nerve syndrome, where the tendons themselves are intact.

This difference serves as the basis for a simple diagnostic test. Where incongruity of the wrist tendons exists, the metacarpal phalangeal joints will be seen in flexion both when the wrist is in full palmar flexion and when it is passively extended. However, in the posterior interosseous nerve syndrome the metacarpal phalangeal joints assume an attitude of extension when the wrist is passively or actively palmar flexed (the so called "tenodesis effect"). (Figures 1 & 2)

One can see, then, that the difference in attitude of the metacarpal phalangeal joints with the wrist in palmar flexion forms a basis for simple office tests to differentiate these conditions. Additionally, of course, electrical testing of nerve function (electromyography and appropriate nerve conduction velocity studies), will be normal in the case of tendon ruptures and abnormal in compression of the posterior interosseous nerve.

It may also be possible to palpate the distended elbow joint with a loss of bony contours in the presence of rheumatoid synovitis. This is perhaps best felt at the lateral aspect of the elbow joint when it is fully extended. In a normal

joint, one can clearly feel the radial head and above it the capitellum with a sulcus (the joint space) in between. This sulcus is frequently obliterated in the posterior interosseous syndrome due to rheumatoid arthritis with its hypertrophic synovium or intra-articular fluid collection.

Cases in the Literature

In 1967, Marmor² reported a case of sudden loss of extension in fingers and thumb originally diagnosed as a rupture of extensor tendons at the wrist. Surgical exploration was carried out,

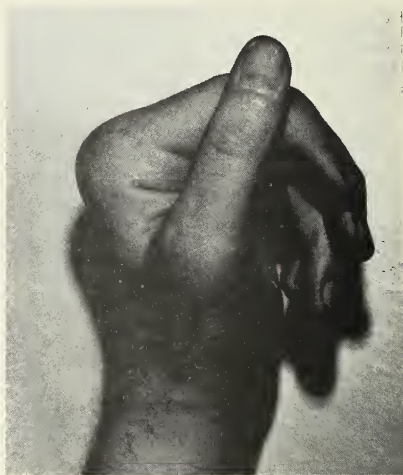


Figure 1
Flexion of metacarpal phalangeal joints with wrist in dorsiflexion.

but the tendons were found to be intact. Steroid injection into the elbow produced complete recovery from paralysis in six months. Two years later it recurred, and was followed by a surgical excision of the radial head and synovectomy of the elbow with good return of function in six months.

Millender³ reported three cases of posterior interosseous nerve syndrome in 1973. The first was a 65-year-old female who noted weakness of finger extensors and then a loss of ability to extend fingers and thumb associated with radial deviation of the hand. Due to minimum recovery



Figure 2

Extension of the metacarpal phalangeal joints with wrist in palmar flexion.

(no treatment was specified) decompression of the posterior interosseous branch of the radial nerve was performed after six weeks through an anterior approach. Partial recovery was reported within 24 hours and full recovery within four days.

His second case was a 49-year-old female who complained of pain at the elbow with "radioneuritis." One week prior to hospital admission, patient complained of weakness in finger extension and subsequent inability to extend the ulnar three fingers, along with weakness of extension in the thumb and index fingers. In addition, the extensor carpi ulnaris was paralyzed. The patient was treated over a one-week period by two injections of intra-articular steroid combined with immobilization of the elbow and a posterior plaster dressing. The duration of immobilization was not specified. Within two weeks early return of function had occurred and full strength was regained in six weeks.

The third case reported was that of a 51-year-old female with a two-year history of inability to extend the ring and small fingers. A rupture of the extensor tendons of these fingers was diagnosed, but the patient refused surgery. Some time later she complained of an inability to extend the long finger. Surgery was performed at the wrist. Tendons were found to be intact and proper diagnosis was achieved.

The delay between onset of symptoms and treatment did not seem to indicate decompression of the nerve and tendon transfers were carried out to restore extension of the fingers and thumb. Subsequent examination revealed weak-

ness of thumb and index finger extension. Electromyography revealed fibrillation potentials in the involved musculature.

Case History

A 34-year-old male was seen by the author in May of 1975. The patient had a history of three years' treatment for inflammatory polyarthritis of a migratory nature. He denied a history of trauma but stated that about a week prior to examination, while lifting his child, he had noted an inability to extend his wrist and fingers. Examination revealed non-functional extensor digitorum comminus, the abductor pollicis longus, extensor pollicis longus, extensor pollicis brevis, and the wrist extensors. A loss of bony contours about the elbow was present although he exhibited a full range of elbow motion, and there was palpably thickened synovium present at the radiohumeral joint. A positive Tinel's sign at the radial head was present.

Radiographs of the cervical spine revealed spondylitic changes compatible with rheumatoid arthritis and films of the elbow revealed diffuse osteoporosis. Electromyographic studies of the musculature did not reveal denervation potentials, as expected in a disease process of such a short duration. Nerve conduction velocities were not obtained.

The rheumatoid factor was positive, and the patient exhibited a consistently elevated sedimentation rate. The antinuclear antibody was negative. The patient was managed conservatively with an injection of intra-articular steroid, and a posterior molded splint was applied for four weeks. The patient was examined at bi-weekly intervals. Two weeks after injection he exhibited active interphalangeal joint extension of the thumb and metacarpal phalangeal joint extension of his other fingers. Upon removal of his dressing (four weeks), he exhibited active extension of his wrist by the extensor carpi radialis longus and brevis, the extensor carpi ulnaris, and active extension of all fingers and thumb by the extensor digitorum comminus and the extensor pollicis longus and brevis. No recurrence of this syndrome has occurred since his initial treatment.

Summary

Painless inability to extend the fingers and thumb actively without associated sensory loss in rheumatoid arthritis caused by compression

of the posterior interosseous nerve is described, along with its anatomic basis. This syndrome can closely mimic the signs and symptoms of common cervical radiculopathy due to rheumatoid disease and extensor tendon ruptures about the wrist from the same cause but requires different therapy. Diagnostic differentiation is important.

Therapy should initiate conservatively, with immobilization of the elbow and one or two intra-articular steroid injections designed to reduce inflammation and swelling. Surgical decompression of the posterior interosseous nerve should be reserved for those patients who present with this syndrome late or who fail to respond to conservative treatment. ◀

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Over the past months this page has been written for those of you who are not members of IMPAC. This month, I would like to address IMPAC members only.

I wish to warmly thank all of you who belong to IMPAC, demonstrating your commitment, as an individual interested in the future of medicine, to political action. The fruits of your commitment are many, but there are greater harvests to reap.

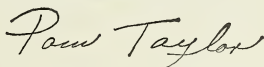
We in medicine have gained a foothold on our destiny through our united political efforts. However, I am sure that most of you agree that we have a long road ahead of us.

Many of you have shown your intense commitment to medical political action by becoming Sustaining Members of IMPAC. I ask those of you who are not Sustaining Members to consider increasing your commitment by becoming a Sustaining Member.

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The "Solution" is the Problem

President Carter's proposal to contain hospital costs is an attempt to cure a problem with its cause. Since government regulation is a primary contributor to rising health costs, more regulation cannot realistically be expected to slow the inflationary spiral.

Hospitals currently are forced to earmark a considerable portion of their resources to comply with Washington's myriad of regulations. For example:

- A 325-bed Los Angeles hospital recorded 1976 expenditures of \$807,046—or \$10.75 per patient day—because of government requirements.
- The West Virginia Hospital Association reported that its member-institutions spend nearly 14% of their budgets to meet government dictates.

Government officials cite the overall health care price tag when attempting to justify the President's proposal. They fail to mention the staggering costs attributed to existing regulations and government's \$1 billion annual expenditure to administer Medicare and Medicaid. Despite the fact that these costs have no direct relationship to patient care, they are tacked on to the total health bill. This type of accounting distorts the health care picture and sets the stage for politically expedient "reforms."

President Carter's proposal conveniently ignores the rising cost of new technology, professional liability insurance, supplies and salaries. Consider this:

- Medicare paid \$4 billion in 1976 for procedures *not even developed* in 1965 when the program began.
- Nearly five percent of the nation's work force is employed in the health care field . . . and wages keep pace with general inflation.

Imposing discriminatory controls on hospitals will have an adverse effect on the quality of care. Apparently the Carter Administration is willing to gamble with the nation's health in the hope of winning dollars and political advantage.

George Wilkins Jr.

George T. Wilkins, Jr., M.D.

Doctor's News

RESOLUTION DEADLINE—Proposed resolutions for the ISMS House of Delegates Interim Session must be received at the ISMS headquarters office no later than October 15, 1977. Resolutions received after that date will be considered late resolutions and require special action for possible inclusion at the Interim Session in November.

ANNUAL AMA AWARDS—The American Medical Association has announced that the nomination deadline for four of their major annual awards is October 1, 1977. The AMA Board of Trustees will consider nominees for the Distinguished Service Award, the Citation of a Layman, the Rush Award and the Scientific Achievement Award at their October meeting. Nominations for the Sheen, Schwartz and Goldberger Awards will be accepted until February 1, 1978. For further information, please contact Mr. Theodore R. Chilcoat, special assistant to the executive vice president, American Medical Association, 535 N. Dearborn St., Chicago 60610.

NO OVERTIME FOR M.D.'s—The AMA has reported results of a recent survey by the U.S. Department of Health, Education and Welfare which found that the typical physician worked 58 hours each week in 1975. According to the Commerce Department's *Statistical Abstract of the U.S.*, the average American work week is 36.1 hours. The AMA found that converting the physician's average net income of \$53,600 to that of a 36.1 hour work week brought the figure down to \$33,400—before deducting the "fringe benefits" most persons receive from their employers.

R & E: IGNORE DRUG RE-REGISTRATION FORM QUESTIONS—Physicians are not required to answer questions appearing on the reverse side of the controlled substances re-registration form. The questions—concerning malpractice suits and conviction of felonies—were included through a Dept. of R&E error. R&E Dir. Joan Anderson apologized for the error and the Dept. has contacted physicians by mail instructing them not to answer the questions. Last year, ISMS obtained a court injunction which blocked R&E from demanding the information as a condition for license renewal.

CONTINUE PROFICIENCY TESTING EFFORT—Physicians who received an Ill. Dept. of Public Health questionnaire concerning clinical laboratory services offered to patients must return the form by Sept. 15. The survey is in response to a 1975 law requiring all physicians performing lab services to undergo one-time proficiency testing. Results of the three-year experimental program will be evaluated to determine the need for permanent legislation mandating proficiency testing.

ANNUAL IPS FALL WEEKEND MEETING ANNOUNCED—The Illinois Psychiatric Society will hold its fourth annual Fall Weekend Meeting, November 11-13, 1977, O'Hare Marriott, Chicago. According to Drs. Jerome S. Beigler, IPS acting president, and Brenda Solomon, M.D., program chairperson, the three-day session will feature symposia, lectures and film presentations on a variety of socio-economic and clinical issues. For further information, please contact Wendy J. Smith at the Society offices, 55 East Monroe, Suite 3510, Chicago 60603, (312/782-1654).

TWENTIETH ANNUAL CONFERENCE ON NUTRITION AND MEDICINE—On October 7, 1977, experts in nutrition from resource centers across the country will meet in Chicago for an informative symposium on the role of food in the medical world. Speakers will address the nutritional needs of persons affected by so-called inborn errors in their metabolism which can be corrected by a prescribed nutritional intake, the role of nutrition as chemotherapy in carcinogenic treatment, research using trace elements for ischemic heart disease, and an in-depth consideration of food as a cultural and political force in history. The Conference, co-sponsored by ISMS, the Illinois Nutrition Committee, the Illinois Heart Association and Blue Cross-Blue Shield, is open to all interested physicians. For further information, contact Marguerite Robinson, Food and Drug Administration, Room 1222, 433 W. Van Buren St., Chicago 60607.

PHYSICIANS IN THE NEWS—Joyce C. Lashof, M.D., former director of the Illinois Department of Public Health, has been named deputy assistant secretary for health in the department of Health Education and Welfare. Her position will entail policy direction for six governmental public health service agencies, and concentrate on health problems of the poor and minority groups in the U.S. Sidney Levitsky, M.D., Northbrook, chief of the division of cardio-thoracic surgery at the University of Illinois Hospital and Abraham Lincoln School of Medicine, has been named to the AMA National Joint Practice Commission. Former senior investigator and senior staff surgeon for the National Institute of Health, Dr. Levitsky will work with a coalition of nurses and physicians for routes to improved health care. . . . Delbert H. Nelson, M.D., Chicago, was elected president-elect of the American Academy of Family Physicians at their annual meeting. Doctor Nelson, immediate past vice president of the academy, is an assistant professor of family medicine at Rush Medical School in Chicago.

Franklin Lounsbury, M.D., River Forest, was elected secretary of the Chicago Medical Society, to fill the position vacated by the sudden death of Doctor Charles Schlageter. Doctor Lounsbury, a trustee of CMS, is an associate professor of surgery at Northwestern Medical School and attending physician at Northwestern Memorial Hospital. . . . Ira M. Rosenthal, M.D., Chicago, was recently elected president of the University of Illinois Hospital Medical Staff. Doctor Rosenthal is also professor and head of the department of pediatrics at the hospital and also the Abraham Lincoln School of Medicine. . . . The July *Doctor's News* erroneously reported that Doctor E. Shannon Stauffer, Springfield, had been elected vice president of the American Spinal Injury Association. Doctor Stauffer resigned as Vice President to accept the post of Director of the Association. He was succeeded by John Young, M.D., a physician from Phoenix, Arizona.

Donald F. Pochyly, M.D., River Forest, has been named provost and acting president of the University of Health Sciences/The Chicago Medical School. The former chairman of the University's department of health sciences education, Doctor Pochyly is an examiner and vice president of the executive committee for the Illinois Council on Continuing Medical Education.

The Chicago Society of Industrial Medicine and Surgery has announced its new officers for 1977-78. Robert S. Kassriel, M.D., Chicago was elected president, Philip Falk, M.D., Chicago, vice-president, John M. Staron, M.D., LaGrange Park, treasurer and Bille Hennan, M.D., Chicago, secretary of the society for the coming year.



report

Illinois Society
American Association of Medical Assistants

Travel Course Seminar Scheduled

The Illinois Society, AAMA, Education Committee will hold the first Travel Course session on Sunday, October 2, from 9:00 a.m. to 3:00 p.m. at the Holiday Inn East, 3100 S. Dirksen Parkway in Springfield (I-55 junction with Route 66 bypass).

The October session will cover both clinical and medical-legal topics. Mr. William P. Isele, staff attorney with the AMA Department of Health Law, will discuss "Legal and Ethical Concerns for the Medical Assistant." His presentation is exclusively addressed to the medical assistant.

Paul Volek, M.P.H., will relate his involvement in organ procurement and preservation for transplantation. Mr. Volek is coordinator for Rush-Presbyterian-St. Luke's Hospital Organ Recovery Program in Chicago.

In addition, a recent update on Medicare regulations will be presented by representatives of the CNA Medicare Division, and a film demonstration on the Heimlich Maneuver will be aired.

Four all-day programs in different parts of the state are scheduled for the coming year. The seminars are intended to bring needed information in a wide variety of areas to all members and medical assistant non-members.

Interested parties should contact Mrs. Nancy Kruger, Registration Chairman, in care of H. R. Keegan, M.D., Suite 201, 401 N. Wall St., Kankakee, 60901 (815-939-3674). Please make checks

payable to AAMA, Illinois Society, Travel Course Program. The cost of \$8 for members and \$10 for non-members includes luncheon.

AAMA Mourns Loss of Physician-Advisor

Carl E. Clark, M.D., esteemed physician of Sycamore, Illinois, passed away July 20, 1977.

Doctor Clark became involved in the Medical Assistants' organization in its early years. He was a strong and steady influence in establishing and maintaining the splendid rapport the AAMA, Illinois Society, now enjoys with the Illinois State Medical Society. He was the founder of the DeKalb County Chapter, AAMA. Over the years he served on the Advisory Boards of the local, state, and national organizations of AAMA and proudly cherished honorary memberships in each one.

Doctor Clark served several years as president of the DeKalb County Board of Health and was an outstanding figure in organizing the Regional Comprehensive Health Planning Committee.

His love for church, family and fellowmen were evident throughout a lifetime of loving guidance and contributions to all who knew him. Doctor Clark was never too busy to become involved in the lives and problems of others. Our mentor will be sorely missed.

CIBA nationwide CHEC program reveals*

**An estimated 13 million
American hypertensives
aren't getting their
medicine.*1**





Illinois Medical Journal

OCTOBER, 1977

Vol. 152, No. 4

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Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.

Abstracts of Board Actions

August 27-28, 1977

Chicago

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

Illinois State Medical Insurance Services, Inc.

Because of possible legal problems involving confidentiality, the Board urged the Illinois State Medical Insurance Services, Inc. not to release the names of Exchange policyholders to anyone.

Office Facilities

ISMS will purchase an appropriate building in Springfield to house the Society's regional office, utilizing the Permanent Reserve for a cash purchase or as collateral on a loan. A five-member Building Committee was appointed to make a recommendation by Sept. 10 to the Executive Committee concerning building selection, method of financing and interior design. The decision to purchase a building was in response to a House of Delegates' directive to seek adequate office space in Springfield. The lease on the current office expires Oct., 1978, and is not expected to be further available.

The Society will lease an additional 2,000 square feet of space on the 34th floor of its Chicago headquarters office building for sublease to Illinois State Medical Insurance Services, Inc. Cost of constructing the offices will be included in rental cost to ISMS over three years with interest of 1% over the prime rate.

ISMS also will negotiate an appropriate lease cancellation with IFMC as part of the HASP phaseout and arrange with the IFMC Board to retain unneeded Foundation equipment in the ISMS offices.

Approve Revised Budget

The Board approved a revised 1977 deficit budget. The current fiscal year marks the end of a five-year plan of allocations—enacted when the House of Delegates approved a dues increase effective in 1973—to strengthen ISMS resources and maintain the dues level.

Request for Reimbursement of Legal Expenses

The Board agreed to transmit to AMA without comment a June 2 Chicago Medical Society letter regarding a request by Dr. Samuel Hoffman, Chicago, that AMA reimburse him for litigation expenses incurred in his suit against the Cook County Hospital Governing Commission. AMA channeled the request through CMS which forwarded it to ISMS "without objection."

Legal Assistance to Members

Based upon advice of legal counsel, ISMS will limit legal assistance to members to the following situations:

- Preparing and filing Friend of the Court briefs in lawsuits involving members (either as plaintiff or defendant) when in the judgment of the Society there are broad issues of public policy, medical economics and/or matters impacting on the nature of medical practice.
- In cases involving medical malpractice and other negligence actions in which the interest of the individual physician is co-mingled with the broad interests of the profession at large, and where providing legal assistance will advance the goals and objectives of the Society and its total membership.

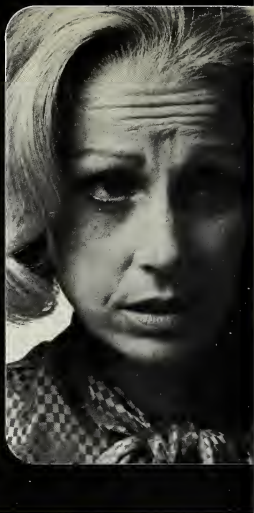
(Continued on page 364)

Clinics for Crippled Children Listed for November

Thirty-three clinics for Illinois physically handicapped children have been scheduled for November by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-four general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be eight special clinics for children with cardiac conditions and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- November 1 East St. Louis—Christian Welfare Hospital
- November 2 Hinsdale—Hinsdale Sanitarium
- November 2 Elgin—Sherman Hospital
- November 3 Sterling—Community General Hospital
- November 3 Springfield—St. John's Hospital
- November 3 DuQuoin—Marshall Browning Hospital
- November 3 Effingham—St. Anthony Memorial Hospital
- November 3 Lake County Cardiac—Victory Memorial Hospital
- November 4 Division Cardiac—U. of I. at the Medical Center
- November 8 Peoria—St. Francis Hospital
- November 9 Champaign-Urbana—McKinley Hospital
- November 9 Chicago Heights General—St. James Hospital
- November 9 Joliet—St. Joseph's Hospital
- November 10 Macomb—McDonough District Hospital
- November 11 Chicago Heights Cardiac—St. James Hospital
- November 14 Peoria Cardiac—St. Francis Hospital
- November 15 Belleville—St. Elizabeth's Hospital
- November 15 Rock Island—Moline Public Hospital
- November 15 Decatur—Decatur Memorial Hospital
- November 16 Springfield Pediatric Neurology—St. John's Hospital
- November 16 Rockford—St. Anthony's Hospital
- November 16 Centralia—St. Mary's Hospital
- November 16 Evergreen Park—Little Company of Mary Hospital
- November 16 Elgin—Sherman Hospital
- November 16 Chicago Heights General—St. James Hospital
- November 17 Pittsfield—Illini Community Hospital
- November 17 Elmhurst Cardiac—Memorial Hospital of DuPage County
- November 18 Chicago Heights Cardiac—St. James Hospital
- November 21 Maywood—Loyola Medical Center
- November 22 Alton—Alton Memorial Hospital
- November 22 Peoria—St. Francis Hospital
- November 22 Park Ridge Cardiac—Lutheran General Hospital
- November 28 Peoria Cardiac—St. Francis Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local, social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.



Cardilate® (erythrityl tetranitrate)

INDICATIONS: For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset is somewhat slower than that of nitroglycerin.

PRECAUTIONS: As with other effective nitrites, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS: No serious side effects have been reported. In sublingual therapy, a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

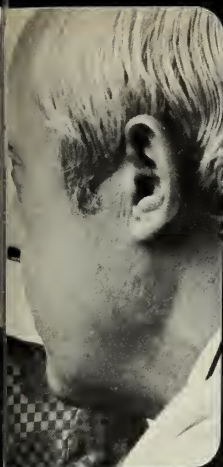
HOW SUPPLIED: 10 mg chewable scored tablets bottle of 100. Also 5, 10 and 15 mg oral/sublingual scored tablets in bottles of 100, 10 mg oral/sublingual scored tablets also supplied in bottles of 1,000.

Also available: Cardilate® P brand Erythrityl Tetranitrate with Phenobarbital® Tablets (Scored) (*Warning - may be habit-forming)



Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709



"Our sex life is nil..." A problem of the first magnitude to many post infarct patients and their mates...patients are often reluctant to broach the subject; physicians may frequently overlook its implications. This new 16mm film combines candid patient interviews with discussions by Drs. Herman Hellerstein, Thomas Hackett, Albert Kattus, Richard Stein, Carroll Witten and Lenore Zohman. Film and related monograph comprise 2 AAFP credit hours. To arrange viewing, write Burroughs Wellcome Co., Educational Services Department, Research Triangle Park, N.C. 27709 or contact your B.W. Co.* representative.

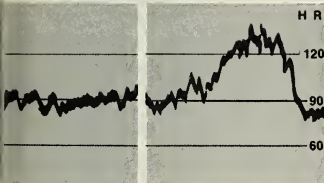
Sex and the heart patient:

A film every doctor should see.

The energy cost of sex to the heart is relatively modest.

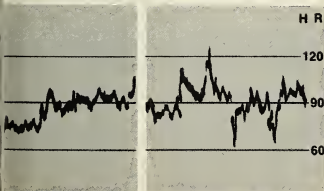
Over 80% of post-coronary patients can ultimately resume sexual activity without serious risk. Hellerstein and Freedman demonstrate that mean maximal heart rate during orgasm with spouse (as opposed to extra-marital sex) in 14 post-infarct patients is lower than that during usual occupational activity.

Representations below of actual EKG readings of an attorney, post MI, illustrate the point:



A Working in office (about 90 beats/min)

B Confrontation in judge's chamber (about 125 beats/min)



C Pre-orgasm sex activity (about 90 beats/min)

D Peaks at orgasm (120 beats/min)



Fear of pain greatest deterrent to post MI sex

In the multitude of MI patients with angina, pain is due to diminished coronary reserve and increased myocardial oxygen demand, precipitated by sex, other excitement and improper exercise. Anginal pain, however, can be relieved, and its recurrence mitigated.

Cardilate® (erythrityl tetranitrate) increases exercise tolerance.

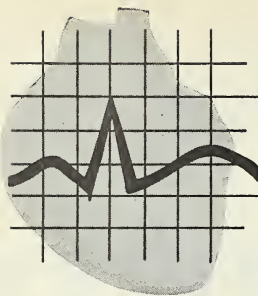
Cardilate relieves anginal pain and prevents its recurrence, thereby allowing increased activity.

Commencing to work in as little as 2 to 5 minutes, Cardilate protects against recurrence of angina for at least 2 hours.

Available in both sublingual and chewable forms, Cardilate is a versatile, convenient agent to help make the angina patient's life more livable.

Cardilate®

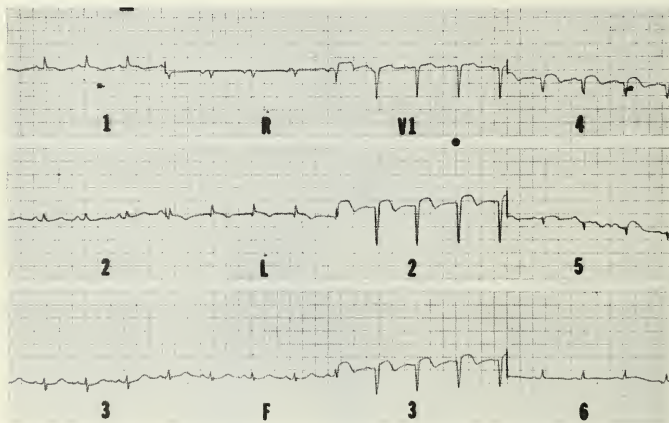
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ekg of the month

JOHN F. MORAN, M.S., M.D., DAVID L. FISHMAN, M.D.,
PATRICK J. SCANLON, M.D., SARAH A. JOHNSON, M.D.,
JOHN R. TOBIN, M.S., M.D., AND ROLF M. GUNNAR, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

A fifty-year-old man had been having short episodes of retrosternal chest pressure for several days. These were unrelated to activity and were frequently blamed on indigestion from his busy luncheon schedule. Then he developed a severe episode of chest pressure with pain in his jaw and left arm. The discomfort waxed and waned for over one hour before he came to the emergency room. Physical exam at that time showed crepitant rales in both lung bases, a loud ventricular gallop, and a blood pressure of 170/90 mmHg. The 12 lead ECG was taken.



Questions:

1. The ECG shows:

- ST segment elevation compatible with pericarditis.
- ST segment changes compatible with a left ventricular aneurysm.
- An acute anteroapical wall myocardial infarction.
- Junctional rhythm with atrioventricular dissociation.
- Peri-infarction block.

2. Treatment for this patient should include:

- Admission to the coronary care unit.
- ECG rhythm monitoring and serial 12 lead ECG.
- Serial determination of enzymes, SGOT, LDH, and CPK.
- Appropriate management in congestive heart failure.
- All of the above.

(Answers on page 379)



the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

Patient is a 45-year-old male who had a history of cholecystectomy two years prior to admission and enters with intractable vomiting and abdominal pain. Examination of the abdomen and an upper GI series was performed. (Figures 1 and 2)



Figure 1



Figure 2

What's your diagnosis?

1. Post-bulbar ulcer with complete obstruction
2. Carcinoma of the ampulla of Vater
3. Pancreatic pseudocyst
4. Lymphoma

(Answers on page 371)

OLBY PROCLAIMS WOMAN SUFFRAGE

**Signs Certificate of Ratification
at His Home Without
Women Witnesses.**

MILITANTS VEXED AT PRIVACY.

**Wanted Movies of Ceremony,
But Both Factions Are**

WASHINGTON, Aug. 26, 1920—
The struggle for woman



TRUMAN CLOSES UNITED NATIONS CONFERENCE WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

**President Hails 'Great
Instrument of Peace,'
Insists It Be Used**

HISTORIC LANDMARK

**Meeting Gives Standing
Ovation as Executive
Pictures Peace Gain**

Social Security Bill Is Signed. Gives Pensions to Aged, Jobless

**Roosevelt Approves Message Intended to Benefit 30,000,000
Persons When States Adopt Cooperating Laws—He
the Measure 'Cornerstone' of His Economic Program**

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

**Amendment to Constitution
is Sent to House, Where
Passage is Expected**

**WASHINGTON, March 10,
1971—The Senate approved
today, 94 to 0, and sent to the**

WASHINGTON, Aug. 10—
The Social Security Bill, part
of a broad program of unemployment
insurance and old age pensions
and counted upon to benefit
20,000,000 persons, became law
today when it was signed by President
Roosevelt in the presence of
those chiefly responsible for
bringing it through Congress.

Mr. Roosevelt called the bill
"the cornerstone in a new program
which is being built for the future
means complete security for all."

the Draft Ends Now

**WASHINGTON, Jan. 27,
1973—**"With the signing of
the peace agreement in
Paris today, and after receiving
a report from the

"If we fail to use it," he declared
to the solemn final meeting of the
delegates, "we shall betray all of
those who have died in order that
we might meet here in freedom and
safety to create it."

"If we seek to use it selfishly—for
the advantage of any one nation or
any small group of nations—we
shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the
auditorium of the War Memorial
Opera House, built in memory of
sons of the Golden Gate city who
gave their lives in the first World
War, in which he himself served,
seemed to give unconscious expression
to the solemn feeling of the
occasion when, at the outset of his
speech, he interpolated the words,
half a hope, half a prayer:

"Oh, what a great day this can
be in history!"



B.W.CO. HAS PUT MORE POTENCY IN THE LINE



EMPRACET® with Codeine Phosphate, 60 mg, No. 4 ©

EMPRACET® with Codeine Phosphate, 30 mg, No. 3 ©

CONTRAINDICATIONS: Hypersensitivity to acetaminophen or codeine.

WARNINGS: Drug dependence. Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to oral narcotics. Subject to the Federal Controlled Substances Act.

Usage in ambulatory patients. Caution patients that these products may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.

Usage in pregnancy. Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.

PRECAUTIONS: Head injury and increased intracranial pressure. Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal condition. These products or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients. Administer with caution to certain patients such as elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

ADVERSE REACTIONS: Most frequently include lightheadedness, dizziness, sedation, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; others include: euphoria, dysphoria, constipation and pruritus.

DRUG INTERACTIONS: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For symptoms and treatment of overdosage and full prescribing information, see package insert.

Introducing EMPRACET® c̄ CODEINE #4

Each tablet contains: codeine phosphate, 60 mg (1 gr) (Warning—may be habit-forming); and acetaminophen, 300 mg.



Our new non-aspirin/ codeine analgesic for moderate to severe pain.

New peach-colored Empracet c̄ Codeine #4 offers a potent alternative for patients in whom aspirin is not indicated.

Unlike compounds containing oxycodone which afford comparable analgesia, new Empracet c̄ Codeine #4 gives you CIII prescribing convenience—up to 5 refills in 6 months at your discretion (where state law permits). And, prescribing by telephone is permissible in most states. Moreover, new Empracet c̄ Codeine #4 has less addiction potential than does oxycodone.

For those of your patients requiring a less potent analgesic, non-aspirin Empracet® c̄ Codeine #3 provides effective relief of moderate pain.

Burroughs Wellcome Co. makes codeine combination products. You make the choice.



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report

Illinois Society
American Association of Medical Assistants

"The Knowledge College"

Have you had a situation occur in your office that had potential legal ramifications and you weren't sure how to handle it? Are you knowledgeable in the procedure of organ procurement or how a person may become an organ donor? These are just a few of the questions we hope to answer for you at the 1977-78 AAMA Illinois Society Travel Courses.

The second AAMA Travel Course will be held on November 13, 1977, in Belleville, Illinois. The first speaker, Mr. William P. Isele, staff attorney in the AMA Department of Health Law, will discuss "Legal and Ethical Concerns for the Medical Assistant." Mr. Isele's program will center on the general principles of law and medical ethics as they relate to the medical assistant's administrative and clinical activities in the physician's office.

Representatives of the ISMS Division of Health Care Delivery and Field Services will then take the floor to answer questions about billing procedures for Medicaid, Medicare and third party payors. Mr. Gary Lessman and Mr. Robert Plowright can lend experience and insight to this important aspect of a medical assistant's administrative duties.

The Kankakee Chapter will hold a symposium on Sunday, November 20, 1977 from 9:00 a.m. to 3:00 p.m. at St. Mary's Hospital Auditorium in Kankakee, on the problems of alcoholism. James W. West, Co-Chairman of the ISMS Committee on Alcoholism and Drug Dependence will discuss "Alcoholism—The Disease," and Doctor Reinhold Schuller will consider "Impaired Physician and Impaired Nurse" in his presentation. Rehabilitation programs for the alcoholic will be the subject of a talk by Mr. Robert Blatner, intermediate care instructor, alcoholism treatment center at Ingalls Memorial Hospital in Harvey, Illinois. For further information and reservations, please contact Mrs. Nancy Kruger, c/o Harold R. Keegan, M.D., 401 N. Wall St., Kankakee, IL 60901.

A general overview of the Organ Donor Program emphasizing the Uniform Anatomical Gift Act, brain death issues, recipient selection and the correct procedure for notification of the procurement team, as well as a film emphasizing clinical aspects, will be included in the discussion of "Organ Donation for Transplantation" by Mr. Paul J. Volek, M.P.H., coordinator of the organ Recovery Program for Presbyterian-St. Luke's Hospital in Chicago. In addition, Mr. Volek will identify organs and tissues currently transplanted and explain the procedure for obtaining and completing the organ donor card.

CNA Insurance, Medicare division, will present an update on new Medicare regulations, a film on how to file a 1490, and also a discussion of the ten most frequently encountered problems in completing Medicare claims.

Four all-day seminars are scheduled for the coming year. The Belleville Travel Course will be held at the Ramada Inn, Fairview Heights (Interstate 64 and Illinois 159) on November 13, 1977. These seminars are designed to be of interest to medical personnel in all capacities, and non-members, as well as members, are urged to attend. Application has been filed for consideration of awarding CEU's.

Registration begins at 8:45 a.m. and the program will be held from 9:00 a.m. to 3:00 p.m. The eight dollar registration fee (\$10.00 for non-members, includes luncheon, and should be made payable to AAMA, Illinois Society, Travel Course. Please detach the form below and mail to: Mrs. Nancy Kruger, Travel Course Chairman, c/o Harold R. Keegan, M.D., 401 N. Wall St., Kankakee, IL 60901.

"The Knowledge College"

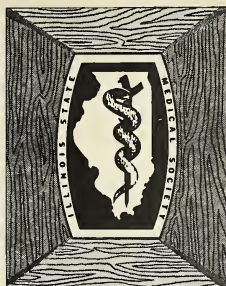
Sunday, November 13, 1977

Name: _____

Address: _____

Employer: _____

AAMA Member: _____ Non-Member: _____



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Illinois Medical Journal

Vol. 152, No. 4, October, 1977

ISMS ORGANIZATION

History of Founding and Expansion

Twenty-nine physicians met in Springfield June 4, 1850, to organize on a permanent basis the Illinois State Medical Society, which had been started informally 10 years earlier. The founders were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first Code of Medical Ethics were adopted, the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp who served for over 35 years until his death in 1959. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960 and served until February, 1966. After an interim service by Dr. George F. Lull, Mr. Roger N. White was selected as Executive Administrator in May, 1968.

The Society published the early transactions in

book form presenting not only the minutes of the House of Delegates, but also all scientific papers given at each annual convention. In 1899 a new era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pence with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen, and Dr. Theodore R. Van Dellen was the editor for the next 18 years.

Dr. Whalen spearheaded many important activities in medicine, and has been called "the outstanding champion of the medical profession in its economic contacts." He has been credited as one of the first medical editors to blast "the socialization of medicine in this country." In 1922, he wrote extensively on state medicine, workmen's compensation, compulsory health insurance, free hospitalization and federal aid.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938.

The fourth largest medical society in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.

Principles Of Medical Ethics

PREAMBLE: These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

SECTION 1—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving

adequate notice. He should not solicit patients.

SECTION 6—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

SECTION 7—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

SECTION 8—A physician should seek consultation upon request, in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

SECTION 9—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

ILLINOIS STATE MEDICAL SOCIETY

Constitution And Bylaws

Adopted, 1903
As Amended, 1977

CONSTITUTION

ARTICLE I. NAME

The name and title of this organization shall be the Illinois State Medical Society.

ARTICLE II. PURPOSES OF THE SOCIETY

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

ARTICLE III. COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Society.

ARTICLE IV. COMPOSITION OF THE SOCIETY

The Society shall consist of active members and such other members as the Bylaws may provide.

ARTICLE V. HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.

Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.

ARTICLE VI. OFFICERS

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, nineteen trustees and one trustee at large, and such other officers as the Bylaws may provide.

ARTICLE VII. BOARD OF TRUSTEES

The Board of Trustees, whose duties are executive and judicial, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

ARTICLE VIII. CONVENTIONS AND MEETINGS

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates which shall be open to all registered members.

ARTICLE IX. THE SEAL

This Society shall have a common seal with power to break, change or renew the same when necessary.

ARTICLE X. AMENDMENTS

The House of Delegates may amend this Constitution at any annual business meeting of the House of Delegates provided that the amendment shall have been proposed at the preceding annual business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

BYLAWS

CHAPTER I. MEMBERSHIP

Section 1. *Members.* Members shall consist of Regular members, Associate members, Emeritus members, Retired members, Service members, Distinguished members, In-training members and Student members. Members enjoy full rights and privileges, including the right to vote and hold office and are counted in determining the strength of the Society's Delegation to the American Medical Association.

A. *Regular Members.* Regular members shall be those physicians licensed to practice medicine in all its branches in the State of Illinois, who are either residents of the State of Illinois or who practice principal-

ly in Illinois, are persons of good moral character and professional standing and members of their ISMS component society.

Members in good standing moving out of Illinois may retain membership (not to exceed one year) in the Illinois State Medical Society until they are accepted into membership in the medical society of the state to which they have moved.

Physicians serving as full-time employees of the American Medical Association and other physicians licensed in one of the states or territories of the United States but not licensed in Illinois may become regular members although they are not actively engaged in the practice of medicine.

B. *Associate Members.* Associate members are physicians who hold the degree of Doctor of Medicine, who have a hospital permit to practice medicine in the State of Illinois and are members of their component medical society.

C. *Emeritus Members.* Emeritus members are those who have been regular members in good standing for thirty-five years and have reached or will have reached the age of seventy before the next fiscal year of the Society, have made written application which is received by their component society prior to December 31 and have been recommended by their component society for emeritus status. Such membership shall be effective January first of the year following election. Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of the Society for at least five years.

D. *Retired Members.* Retired members shall consist of those who have been regular members and who by reason of age or incapacity have retired from active practice and who upon application and recommendation from their component society have been made retired members. Retired status is not available to physicians who assume compensated positions after retiring from medical practice.

E. *Service Members.* Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively fulltime in their respective service, and thereafter if they have been retired on account of age or physical disability, shall be elected to service membership.

F. *Distinguished Members.* Physicians of Illinois or other states or foreign countries who have risen to prominence in the profession, teachers of medicine or of the sciences allied to medicine, not eligible for regular membership, or members of associated arts and sciences, who have made significant contributions to medicine may be nominated by any member of the House of Delegates and may be elected by the House at any annual convention by a two-thirds affirmative vote of those present and voting. They shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other society activities.

G. *In-Training Members.* In-training members are persons who are medical school graduates, of good moral character and professional standing and serving an internship or residency approved by the American Medical Association in the State of Illinois and are members of a component medical society. Membership shall end at the end of the year in which training is terminated. Following this, in-training members may apply for regular membership through their component society.

H. *Student Members.* Student members are those who are currently enrolled in an Illinois medical school or are Illinois residents enrolled in an approved medical school within the boundaries of the United States, are of good moral character, professional and academic standing and student members of a component society.

Section 2. *Discrimination of Membership.* Membership in the Illinois State Medical Society shall not be denied or abridged because of color, creed, race, religion, sex or ethnic origin.

Section 3. Tenure and Termination.

A. *Tenure of Membership.* The name of a physician on a properly certified roster of members of a component society which has paid its annual assessments, shall be prima facie evidence of membership in this society. The member shall retain his membership so long as he complies with the provisions of this Constitution and Bylaws and with the Principles of Medical Ethics of the American Medical Association. A member shall hold only one type of membership at any one time.

B. *Termination of Membership.* Any person who is under sentence of suspension or expulsion from a component society shall not be entitled to any of the rights or benefits of the society nor shall he be permitted to take part in any of the proceedings until he has been reinstated. Non-payment of dues by April 30 of each year shall result in termination of membership.

CHAPTER II. DUES, FUNDS AND ASSESSMENTS

Section 1. *Dues.* Annual dues may be levied by the House of Delegates on each class of membership. The amount of dues shall be recommended by the Board of Trustees and shall be fixed by the House of Delegates at the Annual Meeting and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association. These shall include the annual subscription to the *Illinois Medical Journal* which shall be at least fifty percent of the regular subscription price of the *Journal*. Only Regular, Associate, In-training and Student members shall be assessed annual dues. Dues for its members shall be forwarded by the component society prior to March 31 of each year.

Section 2. *Reduction and Remission of Dues.* Physicians in private practice of medicine may be given a fifty percent reduction in dues during the first year of practice, upon recommendation of their component society. Physicians approved for membership after June 30 shall pay one-half the annual dues for that year. The Board of Trustees may authorize remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association. Emeritus members, Retired members, Service members and Distinguished members are not required to pay dues.

Section 3. *Assessments and Funds.* In addition to dues, assessments may be made on dues-paying members as may be recommended by the Board of Trustees and approved by the House of Delegates. Unless specifically indicated as voluntary, any assessment passed by the ISMS House of Delegates shall be considered a part of a member's dues for the purposes of membership in this organization.

CHAPTER III. EDUCATIONAL AND SCIENTIFIC PROGRAMS

Educational and scientific programs shall be provided by the Society at such times and places as recommended by the Board of Trustees and approved by the House of Delegates.

CHAPTER IV. HOUSE OF DELEGATES

Section 1. *Composition.* The voting membership of the House of Delegates shall consist of 1) delegates elected by component societies, 2) the President, 3) the President-elect, 4) the Vice Presidents, 5) the Secretary-Treasurer, 6) the Speaker and Vice Speaker, 7) Trustees, and 8) one delegate elected by the Resident Physicians Section and one delegate elected by the Student Business Session.

Those having the privilege of the floor without vote are past trustees, past presidents, past speakers, general officers of the American Medical Association, and one representative from each member organization of the Council on Affiliate Societies.

Section 2. *Delegates.* Each component society shall be entitled to send one of its members to the House of Delegates each year for each seventy-five members, not to include student members, and one for a major fraction thereof, but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws shall be entitled to one delegate. The number of delegates to which any component society is entitled shall be determined by the number of members of the component society on membership rolls of the Illinois State Medical Society as of December 31 of the preceding year. The term of office of a delegate shall begin January first following his election and shall be for two years, or until his successor has been elected. Component societies with only one delegate may elect for one year.

Section 3. *Affiliate Group Delegates.* There shall be a Resident Physicians Section and a Student Business Session, which shall be open, respectively, to all in-training and medical student members of ISMS. The business of each organization shall be conducted by a governing council in accordance with bylaws approved by the ISMS House of Delegates. The governing council of each organization shall include one delegate with vote in the ISMS House of Delegates and one alternate delegate.

Section 4. *Time and Place of Meeting.* The House of Delegates shall meet twice each year. These two meetings shall be designated as the annual meeting and the interim meeting. The time and place of both shall be as the House determines, except that the interim meeting should not exceed three days and it should be held in a district other than where the annual meeting is held.

Section 5. *Quorum.* Fifty delegates representing no less than twenty component societies shall constitute a quorum for the transaction of business.

Section 6. *Special meetings.* Special meetings of the House of Delegates may be called by a majority of the Board of Trustees or upon petition of twenty component societies. When a special meeting is called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

Section 7. *Registration.* Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the President and/or the Secretary of his component society stating that the delegate or alternate has been regularly elected to the House of Delegates. A delegate or his alternate may be seated

without credentials, provided he is properly identified and is certified to the secretary of the Illinois State Medical Society. Whenever a delegate or his alternate are unable to attend a particular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate. A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until the final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by the committee. After the alternate has been seated, he cannot be replaced for that session.

Section 8. *District Division.* The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

Section 9. *Order of Procedure.* The order of business of the House of Delegates shall be determined by the Speaker, subject to approval by the Reference Committee on Rules and Order of Business. Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

Section 10. *Privilege of the Floor.* The House of Delegates by two-thirds vote of those present and voting, may extend an invitation to address the House to any person who in its judgment might assist in its deliberations.

Section 11. *Introduction of Resolutions and Other Business.* All resolutions must be introduced by a voting member of the House. Resolution to be printed in the handbook must be submitted nine weeks prior to the annual or interim meeting of the House. Resolutions to be mailed to the delegates prior to the annual or interim meeting must be submitted to ISMS headquarters four weeks prior to the annual or interim meeting. Resolutions submitted after the above date except those originating from the RPS or SBS business sessions, must be approved by the Speaker, Vice Speaker, and one delegate from CMS and one from outside CMS or by a two-thirds vote of the House of Delegates before they will be considered as business of the House. Resolutions presented from the business meeting of the Resident Physician Section or the Student Business Session may be presented for consideration by the House of Delegates at any time before the close of business of the first day session of the House of Delegates.

Reports of committees, councils and officers should be informational and should not contain requests for House action. Recommendations of committees, councils and officers should be submitted to the House in resolution form. Reports, resolutions and requests for action after the opening of the first session of the House of Delegates shall require for consideration a two-thirds affirmative vote.

CHAPTER V. ELECTION OF OFFICERS

Section 1. *Officers.* The officers of this Society shall consist of the president, president-elect, first and second vice presidents, secretary-treasurer, speaker and vice speaker, twenty-one trustees and one trustee-at-large.

Section 2. *Elections.* All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and old business at the final session of the House of Delegates.

Section 3. *Terms of Office.* The president-elect, vice-presidents, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years. The number of consecutive terms that may be served by a trustee is limited to three. This shall become effective July 1, 1975, and shall not have retroactive application.

The speaker and vice speaker shall not be elected for more than two consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following his retirement as president, he shall automatically become trustee-at-large for a term of one year.

CHAPTER VI. DUTIES OF OFFICERS

Section 1. *The President.* The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform such other duties as custom and parliamentary usage may require.

Section 2. *The President-Elect.* The President-Elect shall serve as the chairman of the Committee on Planning and Priorities.

Section 3. *The Vice Presidents.* The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice president, the second vice president will become first vice president.

Section 4. *Successor to President-Elect.* In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at a time recommended by the Reference Committee on Rules and Order of Business.

Section 5. *The Speaker.* The speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint all committees of the House of Delegates.

He shall seek the advice of officers and trustees.

He shall be a member of the Committee on Constitution and Bylaws.

Section 6. *The Vice Speaker.* The vice speaker shall preside for the speaker in the latter's absence at his request. In case of death, or resignation of the speaker, the vice-speaker shall serve during the unexpired term.

Section 7. *The Secretary-Treasurer.* In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

Section 8. *Delegates and Alternate Delegates to the American Medical Association.* Members of the Illinois State Medical Society's delegation to the American Medical Association are officers of this society and, as such, share jointly with the Board of Trustees the responsibility for carrying out policies established by the ISMS House of Delegates as they pertain to the AMA activities.

Members of the delegation are responsible for participating actively in the House of Delegates of ISMS and the AMA to the extent allowed under the bylaws of each organization. They are responsible for submitting to the AMA appropriate resolutions and they are obliged to seek passage of these resolutions in the AMA House of Delegates until such time as circumstances and/or additional facts make continued effort impractical or impossible.

CHAPTER VII. THE BOARD OF TRUSTEES

Section 1. *Composition.* The Board of Trustees shall consist of: twenty-one trustees elected by the House of Delegates, one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and vice speaker of the House of Delegates, the first vice president and second vice president, and the secretary-treasurer. Ten trustees shall be chosen from District 3 and one from each of the other eleven districts.

The trustee districts of the Illinois State Medical Society shall be:

First District—Counties of Kane, Lake, McHenry.

Second District—Counties of Bureau, LaSalle, Livingston, Marshall, Putnam, Woodford.

Third District—Cook County.

Fourth District—Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Warren.

Fifth District—Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon, Tazewell.

Sixth District—Counties of Adams, Brown, Calhoun, Cass, Greene, Jersey, Macoupin, Madison, Morgan, Pike, Scott.

Seventh District—Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby.

Eighth District—Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion.

Ninth District—Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson.

Tenth District—Counties of Monroe, Perry, Randolph, St. Clair, Washington.

Eleventh District—Counties of DuPage, Ford, Grundy, Iroquois, Kankakee, Kendall, Will.

Twelfth District—Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago.

Section 2. *Duties.* The duties of the Board of Trustees are executive, custodial and judicial.

A. *Executive Duties.* The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority.

The Board of Trustees may establish a not-for-profit corporation of physicians known as the Illinois Foundation for Medical Care.

The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

B. *Custodial Duties.* The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board.

The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective.

Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

C. *Judicial Duties.* The Board of Trustees shall be the board of censors of the Society. It shall have jurisdiction over all questions of ethics and in the interpretation of the laws of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to component societies, or to this Society.

All questions of an ethical nature before the House of Delegates or the general scientific meetings, shall be referred to the Board of Trustees without discussion. The Board shall hear and decide all questions of procedure affecting the conduct of members on which an appeal is taken from the decision of a component society.

The decision of the Board of Trustees shall be final except that an appeal may be taken by a member charged with misconduct as provided for in the Constitution and Bylaws of the American Medical Association.

Section 3. *Executive Administrator.* The Board of Trustees shall employ an executive administrator (who, when he shall be a physician, may be designated as the executive vice-president) whose duties shall be determined by the Board. He shall be responsible to the chairman of

the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board also shall employ such other people as are needed for the conduct of the affairs of the Society.

Section 4. *Meetings.* The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

Section 5. *Organization.*

A. *Chairman.* The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year. The immediate past president shall temporarily assume the responsibilities of the Chairman of the Board in the latter's absence.

B. *Duties of the Chairman.* The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board.

Section 6. *Quorum.* Eleven members of the Board of Trustees from at least seven districts shall constitute a quorum for the transaction of business.

Section 7. *County Societies.* The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. *Publication.* The Board of Trustees shall provide and superintend the publication and the distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. *Bonding.* The Board of Trustees shall provide at the expense of the Society, adequate bond for those officers and employees of the Society it considers require bonding.

Section 10. *Duties of Trustees.* Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio member of all district committees. He shall report to the Board of Trustees the actions of the component societies in reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. *Vacancies.* If during the interval between two annual conventions, sickness, death, or removal from the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall

be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12, *The Benevolence Fund*. Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem proper to be held in a fund to be known as "The Benevolence Fund." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. The assets shall be held in the treasury of this Society in a separate fund. Donations or bequests to the Benevolence Fund automatically become a part of these assets.

Section 13, *Audit and Financial Statement*. The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report also shall specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

CHAPTER VIII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Peer Review Committee, and such other committees as required to provide to each component society those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

CHAPTER IX. COMMITTEES

Section 1, *Committee Structure*. The committee structure of the Illinois State Medical Society shall be as follows:

- A. Councils (standing committees)
- B. House of Delegates Committees
- C. Board of Trustees Committees
- D. Ethical Relations Committee (Chapter XI of these Bylaws)

Section 2, *Councils*.

A. The Medical-Legal Council shall be concerned in the areas of:

1. Liaison with the Illinois Bar Association
2. Liaison with courts, particularly where impartial medical testimony is involved.
3. Implementation of the Impartial Medical Testimony Rule
4. Legal aspects of medical practice other than in the area of mental health
5. Licensing and standards of practice.
6. Quackery
7. Anatomical gifts and organ transplants

B. The Council on Governmental Affairs shall be concerned in the areas of:

1. Federal and state legislation—analysis and communication
2. Legislative liaison—both state and federal
3. Political education

C. The Council on Education and Manpower shall be concerned in the areas of:

1. Liaison with medical schools, curricula, etc.
2. Health manpower and training
3. Internships, residencies, etc.
4. Scientific assembly
5. Student loans
6. Liaison with American Medical Student Association
7. Continuing Medical Education

D. The Council on Economics and Peer Review shall be concerned in the areas of:

1. Relations with governmental purchase of care programs (Medicare, Medicaid, Vocational Rehabilitation, etc.)
2. Relations with prepayment, insurance and other third party plans.
3. Fees and fee adjudication
4. Health care cost and utilization
5. Peer Review (Part 2 of Chapter XII of these Bylaws)

E. The Council on Medical Service shall be concerned in the areas of social and medical services and in environmental and community health.

F. The Council on Public Relations and Membership Services shall be concerned in the areas of:

1. Publicity and promotion
2. News media relations
3. Exhibits and public service programming
4. Religion and medicine
5. New member orientation and membership benefit explanation

G. The Council on Mental Health and Addiction shall be concerned in the areas of:

1. Facilities and services
2. Liaison with Department of Mental Health
3. Legal aspects of commitment, etc.
4. Narcotics and dangerous drugs
5. Alcoholism

H. The Council on Affiliate Societies shall be concerned in the areas of:

1. Liaison between the affiliate society and ISMS.
2. Scientific resource information and advice to ISMS.
3. Consultation to other councils, e.g., postgraduate education, health care delivery, publicity, legislation.
4. Advances of medical science in special fields.

I. Planning and Priorities Committee. This committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties, it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President. The President-Elect shall serve as the chairman of the committee.

Section 3. *Organization of Councils.*

A. Councils and the chairmen thereof shall be appointed by the Board of Trustees.

B. Each Council shall have authority to request the Board of Trustees to appoint subcommittees under the councils for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of each subcommittee and shall be selected by the Board of Trustees. Each subcommittee shall be used only for the specific purpose or purposes assigned to it and shall terminate as soon as its final report has been made or at the direction of the Board. The chairman of a Council may not serve as chairman of any subcommittee of the Council.

C. Members of the Illinois State Medical Society (who are not voting members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Students nominated by Illinois Chapters of the American Medical Student Association, or other recognized student organizations approved by the Illinois State Medical Society Board of Trustees to serve with Illinois State Medical Society members on appropriate committees, may by action of the Board of Trustees, be accorded membership in this classification for the term of the committee appointment. Such members shall be permitted full privileges of committee membership, including (with the permission of the House of Delegates) the right to speak on the floor of the House, but to have no vote out of committee. Voting members of the Board of Trustees may serve as advisory members to any council or committee.

Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.

D. Each Council shall submit for adoption a budget for the ensuing year which shall include any subcommittees, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.

E. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils, and may attend all committee meetings.

F. Terms of office of members of the councils shall be one year, but may be terminated at any time at the discretion of the Board. No member of a council shall serve more than five consecutive one-year terms.

G. Vacancies on any council or subcommittee thereof may be filled or membership therein may be enlarged or decreased by the Board of Trustees. The areas of concern of councils may also be enlarged or decreased by the Board of Trustees.

H. The chairman of a council or subcommittee thereof, when he considers it expedient and with the consent of two-thirds of the members of the council, may conduct business or hold meetings by mail or by conference call, provided all members of the council are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all members.

I. Reports of subcommittees shall be made by the chairman to the council under which they are operating. Reports of council activities shall include recommendations on reports and requests from subcommittees, and shall be made to the Board of Trustees by the chairman of the council.

The chairman of any subcommittee may request the Board of Trustees to allow him, or any member of his subcommittee, to appear before the Board and to be heard.

All councils shall submit to the House of Delegates written reports summarizing all actions. Requests for House action or recommendations affecting medical society policy must be submitted to the House in resolution form.

J. *Affiliate Societies*

1. *Qualifications.* Affiliate societies shall be those recognized societies of Illinois

- a) as may be approved by the Board of Trustees
- b) which desire representation on the Council on Affiliate Societies

2. *Representation.* Each affiliate society shall be entitled to one member on the council. This representative shall be a member of ISMS.

Section 4. *House of Delegates Committees.* House of Delegates Committees of the Illinois State Medical Society shall be as follows:

A. Committee on Credentials shall consider all questions regarding the registration and credentials of the delegates. It shall distribute and receive the attendance slips for each session of the House of Delegates and perform any other duties assigned to it.

B. Committee on Rules and Order of Business shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates.

C. Committee on Tellers and Sergeants-at-Arms shall:

1. Serve the speaker of the House of Delegates.
2. Distribute, collect and tally votes when a ballot is taken or a numerical tally is required.
3. Certify those in attendance in closed or executive sessions of the House of Delegates.

D. Committee on Changes in the Constitution and Bylaws shall consider all proposed amendments to the Con-

stitution and Bylaws. The chairman of the Trustees Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee to the House of Delegates.

E. Ad hoc committees may be appointed by the speaker of the House of Delegates as the needs arise and any member of the Illinois State Medical Society may serve upon such committee. The number appointed to such committees shall be at the discretion of the speaker and the term of the committee shall be for such duration as is necessary to complete the task assigned but shall not exceed a duration of one year. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees, keeping it informed of all current activities.

F. Such other reference committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economic activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

Section 5. *Organization of House of Delegates Committees.*

A. Immediately after the organization of the House of Delegates at each annual or special meeting, the speaker shall announce the appointment, from among the members of the House, of such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

B. References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.

C. Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

Section 6. *Board of Trustees Committees.* The Board of Trustees shall form the following committees within itself:

A. The Executive Committee shall consist of the president, president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the chairman of the Policy Committee, the secretary-treasurer, the trustee-at-large, and the immediate past chairman of the Board, provided he is still a trustee. The chairman of the Illinois

Delegation to the American Medical Association, or the secretary in his absence, shall serve as an ex-officio member of the Executive Committee without vote.

The Board of Trustees may delegate to the Executive Committee any authority which it possesses and may authorize it to act in any given situation. In all matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Medical Benevolence Committee and Policy Committee and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

B. The Finance and Medical Benevolence Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

This committee shall also:

1. Examine applications to the Society for assistance under the Medical Benevolence to determine eligibility for assistance;
2. Keep the names of the beneficiaries confidential and known only to the committee;
3. Recommend the allotment for each recipient; and
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

C. The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

D. The Ethical Relations Committee shall be constituted and function as stipulated in Chapter XI, Discipline, Part 2, Illinois State Medical Society procedures.

E. The Committee on Constitution and Bylaws shall consist of five members, the Speaker of the House and four members appointed by the Chairman of the Board. It shall:

1. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws.
2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws.
3. Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

F. The Committee on Publications shall be composed of five members of the Board of Trustees, and shall

be responsible for the production of the *Illinois Medical Journal*.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish format, cover, type faces and general layout of the *Journal*.

It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.

- G. The Advisory Committee to the Auxiliary shall consist of the immediate past president as chairman, the president and the chairman of the Board of Trustees.

The committee shall provide advice and assistance to the president of the Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

- H. The Board of Trustees may from time to time appoint such ad hoc committees as it may deem necessary but the duration of such committees shall be temporary and they shall function only for the specific purpose assigned and shall be terminated as soon as final reports have been made or at the direction of the Board.

Section 7. *Powers of the Board of Trustees.* The Board of Trustees shall have power to increase or decrease the number of its committees, to change the area of concern of such committees, to enlarge or decrease membership and to fill vacancies thereon.

Section 8. *Term of Membership.* The term of the members of the Board of Trustees Committees shall be for a duration of one year and they shall be selected by the Board annually immediately after the election of officers.

CHAPTER X. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Board of Trustees.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving this application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

Section 9. The secretary of each component society shall forward an annual report consisting of a roster of members as of December 31 of the preceding year and a list of current officers, delegates and alternate delegates to the secretary of this society no later than 90 days prior to the annual meeting.

Section 10. Any component society which fails to transmit the dues collected from its members prior to March 31 shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

A member is in good standing unless otherwise disqualified, whose dues are received by ISMS on or before March 31 of the current year. Delinquent members shall

be notified that in consequence of nonpayment of dues, their membership is delinquent. If dues remain unpaid as of April 30 of the current year, membership shall be dropped automatically. The member may be reinstated by paying all delinquent dues, provided, in the interim, he has not been guilty of conduct prejudicial to membership; but if two or more years have elapsed since he was a member in good standing, he must, in addition, make application as a new member.

Section 11. The Constitution and Bylaws of the Illinois State Medical Society and of the American Medical Association, together with the Principles of Medical Ethics of the American Medical Association, shall be binding upon members of the component societies.

CHAPTER XI. DISCIPLINE

PART I. COMPONENT SOCIETY PROCEDURE

Section 1. *Local Ethical Relations Committee.* Each component society may have, either by appointment or election, an Ethical Relations Committee, whose duty it shall be to prosecute formal charges of unethical conduct. In the event that the county society does not have such a committee, the district Ethical Relations Committee shall function in its behalf.

All parties may have legal counsel present to advise and counsel them during the proceedings, but such counsel may not participate in the proceedings, and may be excluded from the hearing by the chairman or by vote of the committee.

The component society Ethical Relations Committee may establish reasonable rules of procedure, and they shall not be bound by the technical rules of evidence as the same pertain in courts of law. In all proceedings before such Ethical Relations Committees, the complainant, the accused and all witnesses before the committee shall be placed under oath.

The Committee shall evaluate acts by the standards established by the House of Delegates of the American Medical Association (specifically known as the Principles of Medical Ethics of the American Medical Association), and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the county medical society.

Section 2. *Offenses.* Any member of a component society shall be subject to censure, suspension or expulsion by such component society when

- A. He has been adjudged guilty by proper civil authorities of a criminal offense involving moral turpitude, or
- B. He has been adjudged guilty by his component society in accordance with the procedural requirement of these bylaws:
 1. of a gross misconduct as a physician, or
 2. of a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association.

Section 3. *Formal Written Charges Presented to the Illinois State Medical Society.* Formal, written charges received by the Illinois State Medical Society shall be referred directly to the secretary of the component society of which the charged individual is a member or to the district Ethical Relations Committee in the event that the com-

ponent society does not have an Ethical Relations Committee.

Section 4. *Principles of Justice.* The following principles of justice shall guide the Ethical Relations Committee in all disciplinary procedures.

- A. A charged individual is presumed to be innocent until he has been proven guilty.
- B. No proceeding shall be initiated under this Part I until formal written charges have been filed with the secretary of the component society or the district Ethical Relations Committee, as the case may be. Thereafter, said formal written charges must be presented under oath or affirmation by the complaining party before the Ethical Relations Committee of the component society or the district Ethical Relations Committee, as the case may be.
- C. A hearing shall be held by the committee within 30 days after the formal written charges have been filed, unless continued by the chairman of the committee upon good cause shown.
- D. In the event that a component society's Ethical Relations Committee does not make a reasonable effort to hold the hearing within the time period, including reasonably granted continuances, either the complaining party or the physician, against whom formal written charges have been brought, may appeal for relief and hearing to the district Ethical Relations Committee, which will determine the reasonableness of the effort.
- E. The individual against whom formal charges have been filed shall be sent a copy of said charges by certified mail at least 10 days before the date set for the hearing, together with a statement of the rights of the charged individual as follows:
 1. to be represented by any member of the society as counsel and that he may have legal counsel present;
 2. to cross-examine witnesses;
 3. to offer in evidence any pertinent records or documents;
 4. to object to any testimony or exhibits offered in evidence;
 5. to address the hearing body in his own behalf;
 6. to be tried only on the specific charges filed;
 7. to have stricken from the record any improper testimony or exhibits;
 8. to appeal to the Board of Trustees of the Illinois State Medical Society.

Section 5. *Records.* A comprehensive stenographic record, tape recording or its equivalent of the entire proceedings, together with all exhibits, must be kept for reference, and shall be available until final adjudication has been made.

In the event of an appeal being taken from the verdict of the local or district Ethical Relations Committee, the stenographic record, tape recording or its equivalent, of the entire proceedings shall be forwarded by certified mail to the Board of Trustees of the ISMS at least ten days prior to the date the appeal is to be heard.

If the component society fails to provide the record on appeal, the Ethical Relations Committee of Illinois State Medical Society shall find the charged individual not guilty.

Section 6. *Verdict.* The committee, sitting as a hearing body, shall recommend the charged individual be found either guilty or not guilty. If the verdict is guilty, the

hearing body shall recommend censure, suspension or expulsion.

The findings of the hearing body must be presented to the component county society for approval or rejection. The charged individual must be notified by certified mail at least ten days before the date set for the meeting at which this action will be taken. If the findings of the component society are against the charged individual, the secretary of the component society shall acquaint the charged individual by certified mail, with his right of appeal within thirty days to the Board of Trustees of the Illinois State Medical Society.

PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 1. *Illinois State Medical Society Ethical Relations Committee.* The Board of Trustees shall appoint from its members, an Ethical Relations Committee to review decisions of the component society involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and Bylaws of the Illinois State Medical Society or its component societies, and charges of misconduct of members of the Society.

Section 2. *Appeals from Component Society Verdicts.* Appeals received by the Illinois State Medical Society Board of Trustees shall be referred to the Ethical Relations Committee of the Board for review. (Appeals must be accompanied by a comprehensive stenographic record tape recording or its equivalent, of the entire proceedings taken before the component county society together with all exhibits submitted in evidence. If the component county society fails to provide the record on appeal, the Ethical Relations Committee of the Illinois State Medical Society shall find the accused "not guilty"). The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for the hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

Section 3. *Verdict.* The Ethical Relations Committee of the Board of Trustees shall hear any new and pertinent evidence any interested party desires to present, and at the conclusion of the trial the decision of the component society shall be affirmed, overruled or sent back to the component society for reconsideration.

Section 4. *Notification and right of appeal.* The secretary of the Society shall notify the defendant and the secretary of the component society wherein the defendant holds membership, of the action of the Board. In the event of a decision against the accused he shall have the right to appeal the decision to the Judicial Council of the American Medical Association and the secretary of the State Society shall so notify the accused of this right.

CHAPTER XII. PEER REVIEW

PART 1. COMPONENT SOCIETY PROCEDURE

Section 1. *Local Peer Review Committee.* Each component Society shall have, either by appointment or election, a Peer Review Committee whose duties it shall be to review all proper complaints and inquiries brought before it by physicians, patients, institutions, insurance carriers, or government agencies.

The district peer review committee shall function and operate on behalf of any county society which does not establish such a committee.

Section 2. The committee shall consist of a chairman and such members representing the various specialties, including family practice, as each individual county society shall determine. Such committee should have access to counsel from each of the various medical specialties. The component county society may establish reasonable rules of procedure but shall not be bound by the technical rules of evidence as the same pertain in courts of law. All proper complaints shall be reduced to writing and shall be signed by the individual making the complaint.

Section 3. Original complaints received by the Illinois State Medical Society shall be referred to the proper county society or to the district committee.

Section 4. The Peer Review Committee shall include the functions of the grievance committee, the prepayment plans and organizations committee, the mediation committee and any other committee having to do with investigations and review but shall not replace or supersede the ethical relations committee.

Section 5. The Peer Review Committee shall initiate consideration of all complaints and matters filed with it within 60 days from the date of filing and shall render an opinion within 30 days after the conclusion of the hearing. In the event the committee does not follow this procedure any party may appeal for relief to the proper district committee whose procedure shall be the same as is set forth herein for county societies.

Section 6. The Peer Review Committee shall have no disciplinary powers but instead, shall report its findings in writing to all parties involved. In the event the investigation and study of the committee results in a determination that there has been a violation of law or unethical conduct on the part of any physician, or a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association, the matter shall be referred in writing to the component society.

Section 7. In its study and deliberations the Peer Review Committee shall evaluate acts by the standards established by the House of Delegates of the American Medical Association (specifically known as the Principles of Medical Ethics of the American Medical Association), and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the county medical society.

Section 8. Any party to the proceedings considering himself aggrieved by the findings and recommendations of the committee shall have the right to appeal through the component society to the Illinois State Medical Society.

Section 9. In the event of an appeal to the Illinois State Medical Society, the county society shall send to the Illinois State Medical Society a copy of the complaint, the exhibits and the opinions of the county or district committee. Any appeal hereunder shall be filed with the Illinois State Medical Society within 30 days after the final opinion of the county or district committee has been rendered.

PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 1. All appeals received by the Illinois State Medical Society shall be referred to the Council on Economics and Peer Review, which shall review opinions of the county or district peer review committee. The council shall have the power to counsel with and obtain information from medical specialists when appropriate. The Council shall have the power to review both the procedural and substantive aspects of any appeal before it.

Section 2. The council upon receiving notice of an appeal shall set the matter for hearing within 30 days after the appeal has been filed and at such hearing shall review the record sent to it from the county society or district society, receive additional pertinent evidence any interested party desires to offer and render its conclusions and findings in writing, copies of which shall be mailed to all interested parties. The Peer Review Committee shall have no disciplinary powers but instead, shall report its findings to all parties involved. The conclusions and findings shall be advisory only.

Section 3. The Council on Economics and Peer Review of the Illinois State Medical Society shall include the functions of the grievance committee, the prepayment plans and organizations committee, the mediation committee and any other committee having to do with in-

vestigations and review but shall not replace or supersede the ethical relations committee.

Section 4. In the event the investigation and study of the Council results in a determination that there has been a violation of law or unethical conduct on the part of any physician, or a violation of the Constitution or Bylaws of his component society, of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association, the matter shall be referred in writing back to the component society.

CHAPTER XIII. MISCELLANEOUS

The fiscal year of this Society shall be from January 1 to December 31 inclusive.

CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any article of these Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

CHAPTER XV. PARLIAMENTARY PROCEDURES

For those matters not covered by the Constitution and Bylaws of the Illinois State Medical Society, Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for conduct of meetings of the House of Delegates, Board of Trustees and all councils and committees.

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1977-1978

Policy Manual

of the

Illinois State Medical Society

"Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience."

"Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy."

This manual shall be a guide for officers, trustees, committee chairmen and headquarters staff to the standard taken by the House of Delegates of the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting for action. The House may:

- (1) approve, amend, or reject—
- (2) refer the statement to the Board for reconsideration and subsequent report—
- (3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House must be presented in resolution form. A member of the Illinois State Medical Society may propose policy by requesting any delegate to submit an appropriate resolution. The Policy Committee will develop policy statements from actions of the House of Delegates and, after approval by the Board of Trustees, the statements will be published in this Policy Manual.

Temporary policy between meetings of the House is determined by the Board. Committees may request Board consideration at any time.

The Illinois State Medical Society shall support policy statements approved by the House of Delegates of the American Medical Association.

National policy is the prerogative of the national association. Until specific contrary action emanates from the AMA House of Delegates, the Board of Trustees and the officers of the ISMS shall consider all such policy as binding.

Policy action at the state level does not rescind official AMA rulings in Illinois.

The same "chain of command" should exist between the county medical society and the ISMS House of Delegates. Policy established at the State Society level must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic process.

PROFESSIONAL POLICIES

Abortion

The decision to perform an abortion is a medical matter to be determined by agreement between the patient and the physician. Performance of abortions should be carried out in accordance with current guidelines as promulgated by the House of Delegates. If not in conflict with state and federal law, an abortion so performed shall not be considered unethical. No physician shall be required to perform or participate in an abortion.

Acupuncture

Acupuncture is a surgical procedure and its practice should be limited to physicians licensed to practice medicine in all of its branches and to dentists.

Alcoholism

Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression, and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational and/or social adjustments as a direct consequence of persistent and excessive use of alcohol.

Insurance companies are encouraged to include appropriate coverage for alcoholism in health insurance policies similar to coverage for any other illness and general hospitals, both public and private, are encouraged to accept alcoholic patients (both in-patient and out-patient) for detoxification and rehabilitation.

Alcoholism Education

The Illinois State Medical Society supports the concept that medical schools and hospital training programs should expand instruction of students in the treatment of acute and chronic alcoholism, as well as its cause and prevention; that mental health clinics should enlarge their services to include treatment and counseling of alcoholics and their families and, where appropriate, collaborate with Alcoholics Anonymous as well as half-way houses; that education programs aimed at alcohol abusers who are drivers should be encouraged and legal restrictions established to prevent them from holding drivers' licenses; that education of the public (at all age levels) regarding the nature of alcohol and its physiologic and psychologic effects should be encouraged.

Ambulance Services

All ambulance services should meet minimum standards as developed from time to time by the Illinois State Medical Society and the State of Illinois.

Athletic Programs

Children of school age, through the 9th grade, should not participate in body contact sports.

Elementary school children develop better physically if activities are informal and not highly competitive.

Medical supervision of all athletic programs is essential.

Audits & Surveys

(Hospital, nursing homes, etc.)

Audits and surveys which impinge on personal privacy, patient care and local hospital trustee and medical decisions as to management should not be condoned.

Birth Control

The preventive medicine approach to the problem of unwanted pregnancies should be encouraged through family life education in the schools, wider dissemination of family planning information, including birth control information and devices, and encouragement of research in population control methods.

Blood Procurement

Inasmuch as blood procurement affects the entire community, any blood procurement program should be carried out only with the approval of the local county medical society involved.

Communicable Diseases

Physicians, especially those engaged in public health work, should enlighten the public concerning all regulations and measures for the prevention and control of communicable diseases. When an epidemic prevails, a physician shall continue his labors without regard to his own health.

Community Health Week

The medical profession shall provide the scientific leadership to focus attention on the health needs of the community and to encourage and assist in developing Community Health Week activities during the winter or spring of the year.

Comprehensive Health Planning

Upgrading of local health facilities should be implemented through Comprehensive Health Planning on a home rule basis rather than through metropolitan oriented advisory services. Where a county medical society is unable to enter into meaningful participation in areawide health services planning, this function may be assumed by an appropriate ISMS District Committee or, where the appropriate District Committee is unable to act, by the Illinois State Medical Society.

Confidentiality

Communications received in confidence by physicians from patients are privileged: the privilege is that of the patient and the physician is the guardian of the privilege and must not betray it. Current day social values dictate that privileges must be continued in accomplishment of the treatment of human illness. Section 9 of the Principles of Medical Ethics states that "A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or the community." The Illinois State Medical Society re-affirms its belief in this principle and supports activities to guarantee continuation of privacy, while recognizing the need for collection of statistical data and enforcement activities in the public good.

The Illinois State Medical Society supports the concept of the confidentiality of the doctor-patient relationship as it relates to the ambulatory patient record and will take an active role in uncovering any violation of the doctor-patient confidential relationship by officials and personnel of review organizations and will take whatever steps are necessary to eliminate the breach of confidence.

ISMS is in total opposition to the use of the Social Security number as a universal number identifier.

Conflict of Interest

When a case of conflict of interest arises and is self-evident, by the attitude shown by the individual concerned, it should be referred to the Executive Committee of the Board of Trustees of the ISMS for consideration.

Continuing Education

Continuing education shall be one of the basic purposes of the Illinois State Medical Society for scientific advancement, humanization of medicine, improvement of medical public relations, and development of cooperation and rapport with the public. The Society should continue to support the multi-faceted approach to continuing medical education as now endorsed by the Illinois Council on Continuing Medical Education.

All members should be encouraged to participate in the AMA Physician Recognition Award, as presently constituted, or its equivalent.

In the certification of educational quality of continuing medical education programs, the Illinois State Medical Society should have a primary role. Physicians should be encouraged to participate in self-assessment test programs prior to registering for such hospital courses and other learning activities.

Cultists, Association with

The Judicial Council of the American Medical Association has ruled that it is unethical to associate VOLUNTARILY with an individual who practices as a member of a "cult."

Current Procedural Terminology

The Illinois State Medical Society endorses the American Medical Association's Current Procedural Terminology and encourages its use by Illinois physicians.

Death, Legal Definition of

ISMS will not support any legislative proposal which seeks to define death unless it provides that, based upon usual and reasonable standards of medical practice, death has occurred when it is determined by a doctor of medicine that a person has experienced the permanent and irreversible cessation of the integrated functioning of the respiratory, circulatory and nervous system, according to the following standards:

- (a) the irreversible cessation of spontaneous respiratory and circulatory functions; or
- (b) if artificial means of support preclude reliance on item (a), the irreversible cessation of spontaneous brain function, which may be confirmed by a flat (isoelectric) electroencephalographic tracing in the absence of hypothermia and of barbiturate and other nervous system depressants.

Death With Dignity

The Illinois State Medical Society will continue to oppose death with dignity, right-to-die and similar legislation, based on what must necessarily be a private matter between physician and patient.

Disaster Control

Any disaster creates an obvious need for trained personnel to aid the sick and injured. Local medical societies should cooperate to provide medical self-help programs. County societies should provide training for their membership in the treatment of mass casualties, radiological casualties and in the organization, operation and maintenance of emergency hospitals.

Discrimination—(see "Freedom of Choice")

Drugs, Prescriptions

Prescription drugs may be dispensed only upon the authorization of a physician licensed to practice medicine in all its branches. Public health departments should not conduct drug dispensing and distribution programs without direct physician supervision of patients receiving medication.

Substitution of prescribed drugs by pharmacists is opposed, except in cases of extreme emergency, unless there be full explanation and agreement by both the patient and the doctor.

The package insert labeling pharmaceutical preparations is a guide for the clinical application of the product and should not be used as an absolute standard limiting the practice of medicine.

Electromyoneurographic Procedures and Examinations

Clinical electromyoneurographic procedures and examinations, which inherently involve medical interpretations, descriptions of findings, and rendering of diagnostic opinions, should be performed only by physicians licensed to practice medicine in all its branches and trained in these procedures.

Ethics

Cases involving ethics shall reach the state society level only by means of an appeal. As outlined in the Bylaws, the state society committee shall serve only as an appellate body to review such cases.

Examinations

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physician in his in-patient activities.

Experimental Medical Procedures

In order to conform to the ethics of the American Medical Association, three requirements must be satisfied in connection with the use of experimental drugs or procedures:

1. The voluntary consent of the person on whom the experiment is to be performed must be obtained.
2. The danger of each experiment must be previously investigated by animal experimentation.
3. The experiment must be performed under proper medical protection and management.

Eyes

Only physicians licensed to practice medicine in all its branches are qualified to prescribe or use eye medications; only such physicians should continue to be the primary entry-point for eye care. ISMS will vigorously oppose any attempt in Illinois to give optometrists a license to prescribe or use medications or to serve as a primary entry-point in the provision of eye care.

Fee Schedules

No member or committee shall be permitted to approve a fee schedule for the Illinois State Medical Society until

it has been submitted to and approved by the House of Delegates or the Board of Trustees. Fees should be commensurate with services rendered.

Foundations for Medical Care

The Illinois Foundation for Medical Care is a not-for-profit corporation established to provide physicians with leadership roles in modifying health care delivery in their communities, thus assuring quality care at reasonable cost.

The Illinois Foundation for Medical Care is completely accountable only to the House of Delegates, through the Board of Trustees of ISMS, and to each component society of ISMS.

Establishment of autonomous county and/or multi-county foundations under the sponsorship of local medical societies is encouraged and, together, local and state foundations shall provide a mechanism through which foundation-sponsored programs can be developed and administered throughout the state.

Freedom of Choice

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

ISMS supports the concept of second opinion—only via the usual and customary referral pathways guaranteeing the free choice of physicians.

Health Care—Ancillary Services

All segments of our population are entitled to and shall receive the best health care available. The physicians in Illinois are encouraged to cooperate in the implementation of any national program meeting with the general policy statements of the Society. (This shall be interpreted to include health aspects in nursing home care, use of recreational facilities, environmental health, public health, employment problems, problems of migrant workers, etc., and any other area which involves the health of the people of this state.)

Health Care Costs

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

ISMS encourages its members to be aware of the cost of hospital services, supplies and drugs.

ISMS is unalterably opposed to governmental control of hospital costs and physicians' fees and reaffirms its faith in the private enterprise system which has made the United States great and strong and which seeks to make health care available to everybody.

Health Careers

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in para-

medical fields shall be provided with all pertinent information.

Health Insurance, Governmental Programs

The Illinois State Medical Society is opposed to compulsory governmentally-mandated national health insurance plans.

Governmental health insurance benefits for mental illness should be comparable to benefits for any other medical condition.

Governmental health insurance programs providing reimbursement for medical services under the direction of practitioners other than doctors of medicine or osteopathic medicine should establish a separate category for such reimbursement, with separate payment, and be optional to the insured.

ISMS will actively oppose any state or federal legislation which proposes reimbursement under health insurance programs of psychologists, social workers or any group of individual practitioners without medical supervision.

Health Insurance, Voluntary Plans

ISMS endorses the principle of voluntary health insurance. Fixed fee schedules should be recognized as indemnification to the patient and not necessarily payment in full.

Inasmuch as the fee coverage by insurance plans may not cover the full fee of the physician, the physician is encouraged to develop a prior agreement with the patient, such as the "Statement of Understanding." This will outline to the patient his individual responsibility for the physician's fee.

ISMS objects to third party carriers interfering with the practice of medicine and the patient-physician relationship by:

- Implying to patients that physician's charges above insurance benefit allowances are excessive;

- Suggesting to physicians that insurance company reimbursement amounts be accepted as payment in full;

- Suggesting that physicians perform alternative surgical procedures.

ISMS endorses long-held principles that:

- A contractual relationship that exists between a patient and a third party does not involve the physician (unless the physician has agreed to such involvement) and

- The third party is not involved in the contract existing between the patient and his/her physician (unless such involvement has been agreed to by both patient and the physician).

Health Screening by Paramedical Personnel

Health evaluation, to be adequate, must include a physical examination only by or under the direct supervision of a physician licensed to practice medicine in all of its branches with physician interpretation of the appropriateness and reliability of various screening procedures used.

Hearing Disorders

Physicians licensed to practice medicine in all its branches remain the primary entry point for the care of patients with hearing impairment.

Hospitals

Physicians should sponsor and assist in the development of all medical staff committees within the hospital.

The local medical profession should cooperate to achieve the accreditation of all eligible hospitals, and should encourage the stabilization or reduction of hospital costs in all areas where they have authority.

All county medical societies are encouraged to form standing committees composed of medical society officers and representative officers of all hospital staffs in their areas to guarantee a free exchange of information between the medical society and hospital staffs related to activities of hospitals, medical organizations, governmental and quasi-governmental agencies in their community.

The Illinois State Medical Society encourages the development of local peer review plans for appropriate review of utilization of hospital emergency rooms.

Hospital—Medical Staff—Management Relationship

Any proposal or arrangement between institutional management and medical staffs should not conflict with the Principles of Medical Ethics or abridge the property right endowed upon the individual physicians by the Illinois Department of Registration and Education. The practice of medicine is the physician's legal prerogative and responsibility. To insure the quality of medical care, each hospital has the obligation to cooperate with and assist its medical staff in implementing procedures by which the quality of medical care in that hospital may be maintained by and through its medical staff.

ISMS is opposed to hospital actions which unilaterally stipulate that professional liability insurance is a prerequisite for membership on a medical staff. If a hospital proposes to require evidence of professional liability insurance as a condition of membership on a medical staff, such condition should be in accord with rules and requirements as established by the organized medical staff of the hospital in cooperation with the hospital board of trustees. To protect their assets, members of a hospital medical staff should be assured of the adequacy (scope and amount) of professional liability coverage carried by the hospital as a reciprocal disclosure between the staff and hospitals.

Hospital Records and Their Availability

Patient care hospital records contain privileged information of confidential nature. Such records are the property of the hospital; information contained therein is held in trust, through a fiduciary relationship, by the hospital.

Patients, and upon appropriate, written authorization, their attorney or succeeding physician, have the right of access to these records, with the ability of review and the right to copy or receive copies. This access is not afforded to patients in cases of psychiatric illness.

Upon receipt of proper, written authorization from the patient, a copy, abstract or summary shall be provided as required, to insurance companies, governmental agencies, or other hospitals.

Patient records utilized by official committees of organized medical staffs to accomplish scientific studies of morbidity or mortality, utilization review, peer review or other patient care improvement activity remain confidential and shall not be disclosed to any person outside the purview of such committees.

Where litigation is involved, a physician may be required to release medical records in the absence of a signed patient authorization. In those instances, a physician should ascertain that he is required to release the medical records and that the agent so requiring the release has the appropriate authority.

Hospital Staff Assessments

The medical staff of a hospital does not have the privilege or the right to make compulsory assessments of members of the medical staff for building funds, or to demand an audit of staff members' personal financial records as a requisite for staff appointments.

Immunization Programs

Illinois residents should be provided access to all medically indicated immunization. Physicians are requested to provide this protection, especially to all children, or to encourage the local public health agency to perform this function.

Every school district should have a school health committee with at least one physician as a member. County advisory school health councils should assist in coordination.

County medical societies should be consulted by health departments planning any mass immunization campaign. In counties where there is no public health department, the Illinois Department of Public Health should contact either the county medical society or local physicians (whichever is appropriate) for coordination of the immunization program.

The Illinois Department of Public Health or the Illinois State Medical Society should institute whatever is necessary, including appropriate state indemnification or "exemption from liability" legislation, to assume or alter the liability responsibility during any mass immunization program.

If private facilities are utilized during a mass immunization campaign, normal reimbursement procedures may be employed, but no charge shall be made for the cost of vaccine paid for by the federal government.

Indigent, The Care of the

Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.

Laboratories

All laboratories providing medical data should be under the direct supervision of a physician.

Marijuana

ISMS does not endorse the legalization of the possession or use of marijuana.

Since the medical and psychiatric knowledge concerning the short-term and long-term effects of cannabis is very limited, medical research should be supported by public and private resources of the State of Illinois.

Medical Care, Provision of

Medical care shall be provided regardless of the ability of the patient to pay. Physicians shall not refuse to render needed emergency care to any patient.

Medical Diagnosis and Treatment

Third parties, including government personnel, insurance carriers, review organizations and hospital personnel should be informed and educated that the Illinois State Medical Society endorses the concept that prognosis and length of treatment must always be individualized to the patient, rather than to the diagnosis.

Medical Education

The Illinois State Medical Society supports development of innovative curricular and co-curricular programs in medical education maintaining a firm foundation in the basic sciences.

Medical Examiners

ISMS favors a medical examiner system throughout the state in preference to a coronor system, wherever practical.

Medical Psychotherapy

Medical Psychotherapy is a medical procedure for the treatment of mental and physical ailments or illness. It involves verbal and non-verbal communications with the patient, and always includes continuing medical diagnostic evaluation and drug management as indicated. Medical psychotherapy may be performed only by a physician licensed to practice medicine in all of its branches, who has had training in psychiatric medicine.

Medical Testimony, Expert Witnesses

An expert medical witness is defined as a physician licensed to practice medicine in all its branches having a basic educational and professional knowledge as a general foundation for testimony and, in addition, having special expertise, current personal experience, practical familiarity, and technical knowledge of the problems that are being considered, as well as alternative forms of treatment, and is currently active in the practice of the medical subject under discussion.

Any physician licensed to practice medicine in all its branches who functions as an expert witness must satisfy the definition of an expert witness, that the definition be a matter of policy, and that it be considered unethical conduct on the part of any physician appearing as an expert witness who does not meet this standard.

Medical Testimony, Impartial

The ends of justice are served when impartial medical witnesses are available to give testimony. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony.

Mental Health

The Illinois State Medical Society strongly opposes the double standard of care in state hospitals and favors elimination of permit physicians (unlicensed physicians practicing in state institutions). Every effort should be made to extend educational opportunities to these permit physicians to enable them to achieve full licensure.

In addition, the Department of Mental Health and Developmental Disabilities should adopt a firm policy for the continuing education of physicians employed by its various mental health centers, allocating state funds necessary to provide high-quality continuing medical education relevant to the needs of these physicians.

Each constituent county society should cooperate fully with and support local units of the Department of Mental Health in their patient care efforts, specifically seeking to encourage:

1. Local general hospitals to accept mental health patients who can be helped by short-term treatment, leaving to state institutions the responsibility for such chronic and long-term cases which local hospitals cannot presently handle.
2. Local general hospitals and practitioners to retain in their own care those geriatric patients who have ailments of primarily a physical nature.
3. Local physicians, local hospitals, and local skilled nursing facilities to provide primary and secondary care for psychiatric problems to the extent possible; given facilities and physician-time available.
4. Arrangements for emergency mental health care, i.e., crisis intervention, to be available areawide.

All physician or other health service provided to the Department of Mental Health, other than that by full-time employees, should be on the same fee-for-service basis as any other medical service which is paid by the patient or third party insurer.

Involuntary psychiatric hospital certification, initial or subsequent, must without exception remain the responsibility of a physician licensed to practice medicine in all of its branches, and a physician licensed to practice medicine in all its branches should be required to certify the discharge of any patient from a psychiatric institution.

Minors, Medical Treatment of

Where parental consent is not legally required for medical treatment of minors, the physician's judgment shall prevail as to whether or not the parents should be notified of such treatment.

Multiphasic Screening

Automated multiphasic health testing and screening laboratories are recognized as an extension of services available to the physician for the health needs of individual patients. A position statement on multiphasic health testing, developed by the ISMS Council on Environmental and Community Health, and the American Medical Association Guidelines for establishing and operating such programs are attached as an appendix to the Policy Manual.

Nurses—Shortage

A severe shortage of graduate nurses continues to imperil the provision of quality patient care. The ISMS supports all forms of qualified nursing education and urges that all such schools be encouraged to remain in operation.

Nursing Homes

Every patient receiving long-term nursing care should have an attending physician who acknowledges his continuing responsibility in writing. Responsible parties, preferably the patient or immediate family, should be urged to select a physician.

Nutrition

Prophylactic use of iron fortified foods is approved in accordance with a 7-point statement developed by the Nutrition Committee and the Council on Environmental and Community Health in 1971.

Occupational Health

Occupational health is an essential ingredient of employee welfare. The adoption and development of health programs in industry should be encouraged.

Occupational health will be advanced through the utilization of industrial physicians.

Osteopaths, Association with

Voluntary professional associations with a Doctor of Osteopathy are not deemed unethical if the Doctor of Osteopathy bases his practice on the same scientific principles as those adhered to by members of the American Medical Association and if he is licensed to practice medicine and surgery in all of its branches in Illinois.

Peer Review

Peer review is the evaluation by practicing physicians of the quality, appropriateness and efficiency of services ordered or performed by other practicing physicians. It is the all-inclusive term for medical review efforts, including utilization review, quality of care, competence determination and ethical considerations.

Medical society peer review shall be conducted at the local level whenever possible.

Physician-Patient Relationship

All committees dealing with the review of physician-patient relationship in hospitals and nursing homes are urged not to release findings to any third parties except by subpoena or court order. Any reports issued by the committees involved should be submitted to the chief of staff for his disposition.

Physicians

The term, "Physician," may only be applied to one who has equivalent qualifications of a "physician licensed to practice medicine in all its branches." The goal of the Illinois State Medical Society is to have this definition made a part of the Illinois Medical Practice Act.

Prepayment Plans and Organizations

It is not within the province of ISMS to act in other than an advisory capacity when working with a "third party plan," and its best efforts should be directed toward supplying guidance, education and communications between the membership and the prepayment plans and organizations involved.

The principle of free enterprise as exemplified by private insurance companies and the "Blue" plans is to be endorsed.

Such plans should recognize that free standing medical and surgical facilities are acceptable methods of delivering high quality health care. Reimbursement for expenses incurred as an outpatient in such facilities should be included in the benefits of these plans.

ISMS is opposed to any legislation which mandates insurance benefits for medical care of psychiatric illness into an optional status.

Prolonging Human Life

Any legislation which proposes statutory restrictions that can intrude into the relationship of the physician and his patient and which may interfere with the physician's ability to use his best judgment and training in caring for

his patient is not in the best interest of either the patient or the public and should, therefore, be unrelentingly opposed.

Psychosurgery

Psychosurgery refers to those surgical operations which irreversibly destroy brain tissue for the primary purpose of treating mental disorders. Psychosurgery does not include procedures undertaken to treat definable disease states such as tumors, epilepsies, aneurysms and chronic pain syndromes, nor does it include electrical stimulation of the brain, such as electroconvulsive therapy. Psychosurgery should not be performed without adequate documentation of indications, adequate consultation and reasoned consent.

Public Aid

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and co-operating with the Illinois Department of Public Aid to maintain the best type medical care for the recipients of state aid.

The fees paid by the state/federal programs to physicians shall be based upon the usual and customary fee concept.

An extensive program of education should be conducted for the recipients of public aid. This should include the intelligent handling of all monies provided.

Rehabilitation of all recipients should be of paramount concern.

Public Health Departments

Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

Full-time modern local health departments adequately financed and staffed at the county or multiple county level are highly desirable and if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support.

Local public health service jurisdictions should be consolidated into sufficiently large geographic and population districts to achieve program efficiency.

Public Safety

Motor vehicle operators should be licensed on the basis of the applicant's physical and mental capacity to operate such a vehicle safely.

Rehabilitation

All physical rehabilitation activities should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.

Relative Value

The Relative Value Study is not a fee schedule and is to be used for information only. All fee payments should be based on the usual, customary and reasonable concept.

No co-efficient shall be established at the state level. The data contained in the study may be used by the ISMS, its committees or by any county medical society.

The study should be revised at appropriate intervals upon recommendation of the Relative Value Committee with approval of the Board of Trustees.

Upon request, copies may be furnished third party purveyors of health care services.

Smoking

The Illinois State Medical Society is opposed to the sale of tobacco and tobacco products in hospitals and will encourage medical staff action to make hospitals tobacco smoke-free.

Specialty Society Representation on ISMS Councils

For the improvement of communication and the discussion of problems of mutual interest and concern, closer liaison between specialty societies of medicine and the councils of the Board of Trustees is desirable. Representatives to serve in this capacity may be nominated by the specialty society, approved by the Board of Trustees of ISMS, and designated as consultants to the council without vote, in compliance with the Bylaws.

Veterans Administration

It is our belief that a Veterans Administration hospital should admit only those patients with service-connected disabilities, except in those instances where the veteran is financially unable to pay for his medical care and hospital services, as shown by a means test.

ADMINISTRATIVE POLICIES

AMA-ERF

The Illinois State Medical Society's dues billing form shall include the names of all medical schools in Illinois so that every member may designate which school is to receive his AMA-ERF contribution.

Assessments

Compulsory assessments of members of hospital staffs for any purpose are unethical and improper.

Autonomy of County Medical Societies

In all areas, the county medical society shall be autonomous, except that no ruling by any county medical society shall conflict with the Principles of Medical Ethics of the American Medical Association or with the Constitution and Bylaws of the Illinois State Medical Society.

Birth Certificates

Birth certificates should contain only such items as are pertinent to their function. Information recorded on birth certificates should not be provided to organizations or individuals for other than approved purposes.

Budgets—(see "Financial Policies")

Committee Appointments

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Elective committees should serve for uniform terms of office—preferably three years. These terms of office should be held on a staggered basis to provide continuity in the committee structure. Individual tenure on any committee should be limited to a maximum of nine years of continuous membership—whether elected or appointed.

Physicians appointed to an Illinois State Medical Society committee must be members in good standing of this Society.

Constitution and Bylaws

Final copy of any changes made by the House of Delegates in the Constitution and/or the Bylaws shall be prepared for publication by the Committee on Constitution and Bylaws, in consultation with legal counsel, making sure that the published changes reflect the thinking expressed by the action of the House.

Co-operation with the American Medical Association

Actions of the AMA House of Delegates are binding upon its membership at all levels, county, state and national.

(Since all members of the Illinois State Medical Society are also members of the American Medical Association, this is universally true in Illinois. The right to disagree, the right to protest, the right to become "the loyal opposition" is not questioned. However, until such time as the AMA House has reversed its decision, it is mandatory that the membership abide by the will of the majority.)

Dues, Recommendation of the Board to the House

The chairman of the Board of Trustees shall place the question of dues for the coming year on the agenda for consideration by the Board of Trustees in time for the Board to present its recommendations to the House of Delegates each year.

Immediately following this meeting, written notice of the recommendation regarding dues for the next fiscal year shall be mailed to all delegates and alternate delegates from the component societies, and also to all presidents and secretaries of county medical societies. This recommendation shall also be published in the *Illinois Medical Journal* as a part of the annual report of the Chairman of the Board.

Education, Primary and Secondary

Primary and secondary education is a community problem. In order to retain jurisdiction of these grade schools, finances should be raised by taxation at the local level.

Election of AMA Delegates

Delegates to the American Medical Association should almost without exception be elected from those having served first as alternate delegates.

Facility Medical Boards (Physicians)

In all legislation which establishes boards for the administration of medical facilities operated by governmental units, at least one-third of the board should be physicians licensed to practice medicine in all its branches.

Federal Funds

When a federal government assistance program is essential it should be conducted under the administration and control of local government. The Society does not favor any federal assistance program which removes administrative control from the state or local level.

Financial Policies

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) ISMS funds used by members campaigning for election as AMA officers, trustees or members of councils or committees must be approved by the ISMS Board of Trustees before such funds are spent for election campaign purposes.

(4) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(5) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(6) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(7) In addition to fixed reserves, the development of a contingency reserve is desirable.

(8) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.

House of Delegates, Special Meetings of

When a special meeting of the House of Delegates is scheduled which may involve an increase in dues or a special assessment, the call for that meeting shall contain specific notification of that possibility.

Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with this Society's basic philosophy.

Informing the Membership

The membership of the Illinois State Medical Society

shall have been properly informed when the following items have been accomplished:

1. Official notice in the *Illinois Medical Journal*;
2. Brief notice in Action Report, outlining the issue and calling attention to the *IMJ* article; and
3. A letter is sent to all county society presidents, secretaries and county executives.

ISMS Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.

ISMS Candidates for AMA Positions

Selection and/or endorsement of ISMS candidates for positions on AMA Board, councils and committees should be submitted to the American Medical Association by the ISMS Delegation, through its chairman, after consultation with the ISMS Board of Trustees or its Executive Committee, except in situations wherein positions suddenly become open, and such consultation is impossible.

Journal Publications

The Publications (Journal) Committee, with the approval of the Board of Trustees, has authority over the publication policy and the screening of all advertisers and advertising copy appearing in the *Illinois Medical Journal*.

Lay Employees' Functions

Policy is established by the House of Delegates.

Staff shall cooperate with officers and committee chairmen in setting up activities and in carrying out all necessary routine.

Staff also shall keep new officers and committee chairmen aware of policy statements, and assist them in the preparation of reports to the House of Delegates to:

change existing policy

establish new policy

request House approval of committee projects and/or procedure involving policy.

Committees shall be informed of their right to set up operating rules and regulations.

Legal Counsel

The legal counsel of the Illinois State Medical Society shall concern himself with official inquiries from officers, trustees, committee chairmen and county medical societies. Such inquiries shall be channeled through the Executive Administrator.

Legislation

All matters pertaining to state or federal legislation shall be referred to the Governmental Affairs Council for consideration and recommendation prior to Board of Trustees and/or House of Delegates action.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Council on Governmental Affairs of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Governmental Affairs which shall work in close cooperation with any other Society committee involved. The instigating committee should determine the content of the law and the Governmental Affairs Council primarily should consider relationship of the proposed legislation to the total legislative program.

Any Council or Committee recommending legislation to the attention of the Governmental Affairs Council must provide expert witnesses when called upon to testify before Senate and House Committees in support of, or in opposition to, the legislation recommended by the Council or Committee.

Legislative Intrusion into Medical Judgment

The Illinois State Medical Society opposes any and all legislative efforts to interfere with physicians' judgment as to which procedures are appropriate and in the best interest of his or her patients and ISMS will work aggressively to oppose any legislation abridging the physician's prerogatives in this regard.

Mailing List

The use of the mailing list of ISMS members must be approved by special action of the Board of Trustees.

Medical Representation in Government Planning

In health programs financed by government funding in an Illinois community, there shall be representation at the highest policy level by an official representative of the State Society and the appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

Only those programs which have involved physicians at the local level in the planning and development stages shall be approved by ISMS.

Unless physicians appointed to the boards and committees of other organizations, such as local Comprehensive Health Planning "b" agencies, are nominated by their local county medical society, such physicians shall not be considered "representative" of the medical community.

Membership in Paramedical and Service Organizations

Membership in Chambers of Commerce (city, state and national) is to be encouraged. This policy extends to the individual physician as well as to the component societies.

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.

Membership of Osteopathic Physicians in ISMS

Osteopathic physicians who meet all qualifications for membership, base their practice on the same scientific principles as those adhered to by members of the AMA, and are licensed to practice medicine in all its branches in Illinois, may be accepted as active members by the county medical societies throughout the state, and be ac-

corded all privileges of full membership at the county and state levels and be so reported to the American Medical Association for acceptance at that level.

Placement Service

Before the Physicians' Placement Service recommends that a town in Illinois be listed as needing a physician, it shall be established that the need actually exists; that the community can support a physician; that certain physical assets (office—home—schools, etc.) are available for the physician and his family.

The qualifications of the physician also shall be ascertained prior to furnishing him with the list of available areas in Illinois needing a physician.

Policy Statements

Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience.

Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy.

Polls, Opinion

The Board of Trustees is responsible for ascertaining the opinion of members on critical issues facing the society. Periodic membership opinion polls should be considered as one means of ascertaining member opinion. However, the vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership since delegates are the duly elected representatives of their county medical societies and it is the responsibility of the delegates to determine the thinking of their constituents so that their voting will express this opinion. The majority opinion is expressed in the House of Delegates and it should be unnecessary to conduct a membership poll except under very exceptional conditions.

Press

All county medical societies should be encouraged to cooperate with the local press. The public should be provided with prompt and accurate information in all health fields; the source of this information should be the medical profession.

County medical societies should provide information at the local level; the State Society is responsible for press releases involving State Society officers or any official statements of the Society appearing in the press.

A code of ethics applicable to medicine and the fourth estate should be developed. (That used in the Decatur area has been given national recognition by the AMA.)

Professional Liability

The Illinois State Medical Society endorses the concept of effective peer review in all matters related to the professional liability of physicians including the right of individual physicians to appear before appropriate peer review committees responsible for his liability insurance coverage.

The Illinois State Medical Society should protect the interests of its members by encouraging the provision of a guarantee of due process in the bylaws of the Illinois State Medical Inter-Insurance Exchange.

Publication of Research Data

In releasing research material for publication in the *Illinois Medical Journal*, or any other media, extreme care should be exercised. The welfare and privacy of the patient, and the professional reputation of the physician should be of primary concern.

If any question arises, consultation with the Board of Trustees is suggested. All such inquiries should be addressed to its chairman.

Public Affairs

No officer or member of the Board of Trustees should be permitted (during his term of office) to allow his name as an officer or a member of the Board to be used in lists endorsing candidates for public office. Naturally his right to this privilege as a private individual is not affected.

Rebates

In conformity with the AMA Principles of Ethics, rebates of any nature to any member, county or regional medical society, are unethical. This statement on rebates was developed as a result of a letter regarding collection services. It read in part:

"It is our policy to remit to a participating association the sum of 10 per cent of the gross book sales to its members in addition to 10 per cent of the gross commissions received from collections. A report and accompanying payment is submitted monthly from our office."

Reference Committee Appointments

Whenever possible at least two members shall be retained on all reference committees for the following year in order to effect continuity of experience.

Reference Service

Physician reference service shall be the responsibility of the county medical society. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.

Resolutions

Since the relationship between the Illinois State Medical Society and other voluntary physician membership organizations is the responsibility of the Board of Trustees, the Speaker of the House of Delegates shall refer to the Board any resolutions making reference to other voluntary physician membership organizations not affiliated with ISMS.

Stationery, Use of Official

No officer, trustee, committee chairman or staff director is to use the official stationery of the Illinois State Medical Society for personal statements of any nature. This shall pertain especially to the endorsement of any candidate for public office.

Surveys

The Illinois State Medical Society endorses the principle of mass surveys and encourages the use of this method whenever it meets with the approval of the local county medical society.

Any new state program involving more than one county society should be submitted to the Board of Trustees for initial approval.

Uniform Health Insurance Claim Form

The Illinois State Medical Society supports the use of the Health Insurance Claim Form developed by the AMA Council on Medical Service by all insurance carriers and physicians.

Policy Manual

APPENDIX

Multiphasic Health Testing Council on Environmental and Community Health Statement

During the recent past there has been an upwelling of various automated or multiphasic health testing or screening programs. The use of the results of such testing has at times led to a false sense of security on the part of patients, whereas other programs are being foisted on the public with the view to making money with very little concern for an individual's well being. Other programs are offered as having direct, immediate and prac-

tical medical value, without review by a physician. These many concerns prompt the necessity of a position statement on the use and application of such programs.

There is a place for computer and automated multiphasic testing and screening programs as an extension of the services available to the physician as he considers each individual case. It is entirely possible that such a mechanism will enable a physician to expand his scope of operation.

Forms of automated multiphasic health testing have been used by public health agencies and centers for developmental research in epidemiology. In these programs, asymptomatic control patients have been tested. Testings have been done to establish medical priorities or case findings in communities. Other testing has been done to separate those who probably have certain characteristics from those who do not.

Occupational or industrial health programs have used testing programs for the betterment of employees' health and working conditions. Programs such as these, whether a pre-employment examination or a study to control health hazards, are not necessarily related to medical care as such. The physician in charge may or may not at the same time be the attending physician of the employee.

As far as automated multiphasic health testing programs for individuals are concerned, these programs obtain health-related data and act as data collecting sources, following a routine using technicians or mechanical and electronic devices to determine facts. In several hours a variety of tests and measurements can be made which may provide a profile of an individual's physical status. Such a profile can be of value to a physician. The testing is not diagnosis or interpretation.

Some individually oriented automated multiphasic health testing programs are operated commercially on a for-profit basis. Many of these do determine and report facts accurately. Some, however, give the appearance of encouraging individuals to be tested without a medical referral for the tests. Some indicate that when the results are compared against standards or norms the individual does not even have to see a physician. Some, in addition, perform a battery of tests which are not requested by an attending physician.

The physician's ethical responsibility is to provide his patient with high quality services. He should not utilize services of any testing program unless he has the utmost confidence in the quality of its services. He must assume professional responsibility for the best interest of the patient. As a professional man, the physician is entitled to compensation for his services. However, he should not be engaged in the commercial conduct of a testing or screening program and should not make a mark up commission or profit on services rendered by others. It is not, in itself, unethical for a physician to own an

automated multiphasic facility or interest. The use of the physician makes of this ownership may be unethical.

An attending physician may not receive a rebate, referral fee, or commission from a program whose facilities have been used by his patients.

An automated health testing facility is a fact finding and reporting system. It must be limited to fact finding and exclude interpretation. Findings disclosed must be interpreted only by physicians.

Offering a combination of medical and non-medical service to the public is to be avoided. The public may be confused as to what constitutes reporting a fact and what constitutes the making of a medical diagnosis.

A practicing physician may recommend multiphasic health testing where he believes it may be helpful to him in the care of his patient. Prudence dictates that the physician be selective in recommending or requiring patients to utilize the services of an automatic health testing facility and not adopt the practice of routinely requiring that all patients, or all new patients, undergo such testing. When good medical judgment suggests the desirability of such testing, the physician should explain in general the nature and purpose of the testing. The patient must be afforded freedom to choose between automated multiphasic health testing facilities, if available. Alternatives in the way of single tests should be offered patients, where possible and practical.

An individual who is tested, or a facility which conducts these tests, may neither demand that a physician accept an individual as a patient nor evaluate the tests for the individual. The physician remains free to choose whom he will serve.

A physician employed by an automated multiphasic health testing facility, in conformity with well established policies, should not dispose of his professional attainments to any corporation or to a lay body under terms or conditions which permit the sale of the services of that physician by an agency for fee, nor allow his name or the prestige of his professional status as a physician to be used in the promotion of a commercial enterprise. He should neither aid nor abet an unlicensed individual or corporation to practice medicine.

There is a responsibility for the medical society to educate the public regarding indications for and against multiphasic health testing, to educate the membership of the society regarding ethical responsibilities in these matters, and the society must be ready to assist persons or corporations that seek advice in setting up multiphasic health testing facilities.

AMA Guidelines for Establishing and Operating Multiphasic Health Testing Programs

The following guidelines are recommended for use by physicians and medical societies in providing technical advice and assistance in the planning, development, implementation, and operation of multiphasic health testing programs:

1. Multiphasic health testing is a method of acquiring, storing, collating, and reproducing medical data on individual patients. The testing procedures are considered to be incomplete health services. Provisions must be made for a physician to interpret and evaluate this medical data base as an aid in continuing patient care.
2. The multiphasic testing program should meet applicable licensing requirements and be appropriately evaluated for quality control.
3. Physicians must be involved in the planning and development of testing programs.
4. The operation of all MHT programs must be supervised by qualified physicians at the testing center, particularly in regard to any abnormal findings, and these physicians must see that the patient is instructed to obtain medical advice for significant abnormal findings.
5. The system should be designed to make maximum

- use of allied health professionals and should utilize technical and automated techniques where justified.
6. For professional value and economic feasibility, the program should include tests that are simple, safe, easy to interpret, inexpensive and quick to perform, and that have acceptable sensitivity, specificity, high predictive value, and patient acceptance.
 7. The testing system should include the following criteria: reliability, accuracy of output, saving of time of physicians and allied health personnel, adequate utilization, and sufficient flexibility for customization to physician and patient needs. The program should establish individual ethnic, geographic, and other variations of normal and abnormal patterns.
 8. The program should provide for confidentiality of patient data.
 9. The testing program should be used, where feasible, to meet otherwise unmet community health needs

and should be integrated into the continuing health care system.

10. The testing program should be designed to meet various objectives such as diagnostic services, health maintenance, and guidance in management of ongoing illness including chronic disease.
11. Evaluation methodology should be built into the program to determine the acceptance and use, yield, false positives and false negatives, as well as the long-term effects of the program on illness and the need and demand for health services. The program should include a documented accounting system, at least for internal use, and a reasonable cost finding system that would allow for cost analysis and cost summaries.
12. The program should maintain freedom of choice for both the physician and the patient.

MINIMUM STANDARDS FOR HEALTH INSURANCE PROGRAMS

The following minimum standards for health insurance programs, developed by the Illinois Foundation for Medical Care and approved by the IFMC Board of Directors May 17, 1975, were adopted by the Illinois State Medical Society:

The Recommended Minimum Standards for Health Insurance Programs, as follows, is a method of referring to the type of benefits that the Illinois Foundation for Medical Care feels it would be willing to endorse. These minimum standards incorporate adequate outpatient, X-ray and laboratory benefits, consultations in and out of the hospital and coverage from birth.

I. General Standards for Basic, Excess Major Medical and Comprehensive Major Medical Group Insurance Programs

- A. Unless otherwise specified in these minimum standards, all requirements of these minimum standards apply to both insured and dependent.
- B. Coverage shall be provided for dependents who are defined as spouse and dependent children from birth to age 19 and to age 23 if attending college. Routine nursery care should be included.
- C. Unless otherwise specified in these minimum standards, all services covered in the contract are covered regardless of whether performed in the home, office, hospital or ambulatory surgical treatment center.
- D. Psychiatric care should be included.
- E. All programs shall provide for coordination of benefits (anti-duplication).
- F. All contracts written shall provide payment of benefits in accordance with the usual, customary, or reasonable fee concept.
- G. Professional payments should be restricted to duly licensed:
 1. Physicians and surgeons (Doctors of medicine and of osteopathy);
 2. Doctors of Dentistry; and
 3. Doctors of Chiropraxy.

II. Required Medical Coverage

Unless specified, all coverage is to provide at least

80% of Usual, Customary and Reasonable charges.

- A. First consultation on new or former patient requiring limited examination of given system, but not requiring a complete diagnostic history and examination: home, office or hospital. (CPT 90600)
- B. First consultation on new or former patient requiring more extensive examination; but not requiring complete diagnostic history and examination, home, office or hospital. (CPT 90610)
- C. First consultation on new or former patient requiring complete diagnostic history and examination; office, home or hospital. (CPT 90620)
- D. First consultation on new or former patient of unusual complexity (in excess of scope of service identified in A, B and C above) necessitating diagnostic history and examination, extensive review of prior medical records, compilation and assessment of data, and the preparation of a special report; home, office or hospital. (CPT 90630)
- E. Prolonged detention with a patient in critical condition or requiring constant care and attention beyond usual service, per hour. (CPT 99040)
- F. Medical calls on an in-patient basis for each day of covered hospital room and board benefits.
- G. Miscellaneous procedures—dialysis, chemotherapy and desensitization in office or hospital are to be covered.
- H. It is understood that all procedures not listed may be excluded from the contract, but it is further understood that these procedures, when performed, may be billed directly to the patient.
- I. Well baby care, including immunizations, 0 to 12 months.

III. Required Hospital Coverage

- A. At least a \$50-a-day rate for a minimum of 70 days for each illness and injury per contract year.

- B. At least \$1,000 for miscellaneous hospital charges for each illness and injury per contract year. This benefit will also apply if the surgery is approved on an in-hospital out-patient basis in lieu of hospitalization as outlined in the surgical coverage. In-hospital charges and emergency room charges for laboratory and X-ray tests and services shall be covered under this benefit.
- C. At least twice the normal average semi-private rate to be allowed for care in intensive care units and cardiac care units. (A limit of 80% of the charge would also be acceptable).
- D. At least \$15.00 for surgical tray charges on out-patient surgery performed in a physician's office, subject to the contract limits for miscellaneous hospital charges.
- E. Ambulance charges to and from hospital within maximum of \$50.00 per trip.
- F. Hospital charges for the use of their emergency department facilities are payable, subject to the contract limits for miscellaneous hospital charges.
- G. It should be understood that if circumstances, such as age or marital status, lessen the need for maternity benefits, then underwriting decisions will incorporate appropriate lower costing or emphasis on such coverage. Hospital coverage shall include:
 - 1. Coverage from birth for dependent children, including routine newborn nursery care.
 - 2. Coverage for normal delivery with a minimum of \$200.00.
 - 3. Coverage for ectopic pregnancy.
 - 4. Coverage for miscarriage and D&C's.
 - 5. Coverage for an initial cesarean section (after a deductible of \$150.00 if no basic maternity covered).
- H. Hospital service in the hospital's out-patient department shall be covered with maximum in accordance with Item B above.
- I. The responsibility fee charge for replacing whole blood or blood plasma is not covered, but the processing fee costs should be included as a covered item under the hospital charges.

IV. Required Supplemental Accident Coverage

- A. At least \$300.00 of supplemental coverage per year shall be provided for accident care for subscribers and dependents in or out of the hospital, and payable on the basis of usual, customary and reasonable fees when not covered under the Base Plan Benefits.

V. Required Radiology and Laboratory Coverage for Professional Services Only

- A. At least 80% of laboratory and/or X-ray physician services up to \$1,000 for each illness or accident shall be provided per individual per contract year, irrespective of whether the patient is in or out of the hospital. (A \$100 deductible is acceptable).
 - 1. All cardiovascular procedures including cardiac catheterizations and other vascular studies.

- 2. All pulmonary laboratory procedures including physician services and interpretation.
- 3. All skin testing for cell mediated (delayed hypersensitivity) function.
- B. In addition to the above benefits, a separate benefit will be allowed for radiotherapy and radioactive isotope procedures for treatment of illness and injury when deemed medically necessary, up to a maximum of \$500 per patient per contract year.

VI. Required Out-Patient X-Ray and Laboratory Tests

- A. \$150 maximum per contract year.

VII. Optional Changes or Additions to Basic Coverage

- A. Out-patient Medical Care
 - 1. May have a 2-visit deductible.
 - 2. May provide for the following procedures, reimbursed at 80% of usual, customary and reasonable charges.
 - a. Office calls (This to include 12 psychiatric visits.)
 - b. Home calls
 - c. Generally-accepted allergy testing and treatment
 - d. Intermittent positive pressure breathing
 - e. Emergency department calls
- B. Preventive Medical Care
 - 1. Include payment towards preventive medicine, e.g., annual physical on a co-insurance basis.
 - 2. Include at least \$50.00 towards well-baby-care during the first year of life.
- C. Normal Maternity Care
 - 1. If normal maternity allowances are provided, they are to be applied to any deductibles allowed for cesarean section in the contract.
- D. Blood and Blood Plasma
 - 1. Include responsibility fee costs after the first three pints.
- E. Skilled Nursing Care
 - 1. Benefits for skilled nursing care facilities should approximate 50% of basic hospital plan.

VIII. Required Surgical Coverage

- A maximum-per-procedure limit of liability should be specified for surgical coverage, and it shall not be less than 80% of the usual, customary and reasonable cost for that procedure.
- A. Physician anesthesiologists shall be covered according to their usual, customary and reasonable charges in addition to any maximum surgical allowances.
- B. Coverage for dependent children must start at birth and include circumcision.
- C. The following procedures listed under the Medical section shall be covered but shall be paid under the Surgical portion of the contract:
 - 1. Assembly and operation of pump with oxygenator or heat exchanger.
 - 2. Monitoring ECG, pressures, etc., in intra-thoracic or other critical surgery.
 - 3. Phlebotomy, therapeutic.

- D. Normal delivery, including pre- and post-partum care, ectopic pregnancy, cesarean section (for initial cesarean section less \$150 if no basic maternity coverage) and D&C shall be a benefit irrespective of provisions on maternity benefits. Payment is for surgery and post-operative care.
- E. Surgical procedures covered in the hospital are likewise a benefit when done on an out-patient basis in the physician's office or an approved ambulatory surgical center provided the latter is considered good medical practice in the community by the Local Review Committee. A surgical tray charge shall be allowed in the physician's office as part of the \$1,000 miscellaneous hospital allowance.
- F. Physicians acting as assistant surgeons shall be covered and their fees shall be in addition to any maximum surgical allowances with a maximum not less than 80% of that which is usual, customary and reasonable.

IX. Surgical Exclusions

- A. Cosmetic procedures except those that are necessary for post-traumatic or post-oncology treatment.

X. Minimum Standards for Major Medical Group Insurance Programs

(i.e., SUPPLEMENTAL MAJOR MEDICAL OR TO BE USED WITH BASE PLANS AS A SUPPLEMENTAL MAJOR MEDICAL)

- A. Coverage provided in base plan must conform with the Minimum Standards for Basic Group Insurance Programs.
- B. Supplemental major medical coverage must include all items as outlined under comprehensive major medical of these standards.

XI. Minimum Standards for Comprehensive Major Medical Insurance Programs

- A. Minimum Limit
 - 1. The minimum aggregate amount payable for all covered benefits per disability for each patient is at least \$25,000.00.
- B. Automatic Restoration
 - 1. The maximum of \$25,000.00 is restored automatically on January 1st of each year for the lesser of:
 - a. \$1,000.00
 - b. Amount of benefits used during the previous calendar year.
- C. Hospital Benefits
 - 1. At least 80% of the covered or medically necessary hospital services and supplies during hospital confinement. A \$100.00 deductible may be applied per each calendar year. Hospital daily room and board charges are payable up to 80% of the semi-private room rates.
- D. Services by physicians and surgeons are not payable under hospital benefits.
- E. At least 80% of other covered expenses including critical care units.

- F. When ordered by a legally qualified physician or surgeon, the other covered expenses referred to above (E) are:

1. Services of a licensed or graduate nurse, other than a person who ordinarily resides in the insured person's home or who is a member of the insured person's immediate family (comprised of the insured person's spouse and the children, brothers, sisters and parents of such insured person's spouse.)
2. Anesthetic supplies
3. Treatment by a physiotherapist (other than a member of the insured person's immediate family (defined above)).
4. X-ray and laboratory services, or the technical components thereof, billed by and as a hospital service, with the exception of:
 - a. Dental X-ray unless rendered as a part of dental treatment of a fractured jaw or an injury to natural teeth while insured under the contract.
 - b. Laboratory and X-ray services done on an out-patient basis will be covered as a professional benefit.
5. Professional ambulance service up to \$50.00, except service by railroad, ship, bus, airplane, or other common carrier.
6. Medical supplies:
 - a. Drugs and medicine dispensed by a licensed physician, or by a licensed pharmacist when prescribed by a licensed physician or surgeon, and when for the specific illness or accident for which the patient is being treated.
 - b. Artificial limbs and eyes.
 - c. Surgical dressings.
 - d. Casts.
 - e. Splints.
 - f. Trusses.
 - g. Braces.
 - h. Crutches.
 - i. Rental of wheel chairs, hospital beds or iron lung.
 - j. Oxygen and rental of equipment for its administration.
 - k. Other durable therapeutic equipment when approved by the medical review board.
7. See maternity benefits.
- G. When medically indicated, a patient may be admitted to an extended care facility in lieu of hospitalization.
- H. Surgical procedures covered in the hospital are likewise a benefit when done on an out-patient basis in the physician's office or an approved ambulatory surgical center, provided the latter is considered good medical practice in the community by the Local Review Committee. A surgical tray charge shall be payable in the physician's office.

XII. Maternity Benefits

- A. Irrespective of any allowances made for normal delivery, all professional services, hospital, and ambulatory surgical facilities shall be covered in full for cesarean section, ectopic pregnancy, D&C and miscarriage. (Except that the deductible may be applied to the hospital portion).

- B. Complications of pregnancy are covered in accordance with the contract and not as maternity benefits.
- C. If maternity benefits are provided, they may be covered by one of the following methods:
 1. Flat dollar coverage—If a flat dollar amount is allowed for normal maternity, this benefit should be divided 50% for the hospital and 50% for professional services.
 2. Front end deductible—If a front end deductible amount is applied, the deductible should not exceed \$400.00. After the deductible has been satisfied, benefits should cover at least 80% of the expenses.

XIII. Out-Patient Psychiatric Benefit

Out-patient physician-performed procedures for psychiatric illness shall be covered on an 80% UCR co-insurance basis for the first 12 visits per year and 50% UCR co-insurance basis for 8 subsequent visits in that same year.

XIV. Exceptions

This plan does not cover loss caused by or resulting from:

- A. Injury or sickness which arises out of or in the course of any occupation or employment for wage or profit.
- B. Declared or undeclared war or any act thereof.
- C. Service in the Armed Forces of any country.
- D. Cosmetic surgery, except for treatment made necessary by oncological defect, or by injury sustained in an accident while the insurance is in force.
- E. Dental treatment, except dental treatment made necessary by injury to sound natural teeth sustained in an accident while the insurance is in force.
- F. Eye refractions or the fitting of glasses or hearing aids.

- G. Expenses incurred for a newborn child during the period the mother is hospital-confined for medical examinations and "check-up" purposes, except where medically indicated and necessary to the treatment of such child.
- H. Expenses incurred during confinement in a hospital owned and operated by the United States Government or any agency thereof, or for the services, treatment, or supplies furnished by or at the direction of the United States government or any agency thereof.
- I. Expenses incurred during confinement in a hospital owned or operated by a state, province, or political subdivision, unless there is an unconditional requirement on the part of the Covered Person to pay such expenses without regard to any liability against other, contractual or otherwise.
- 1. Any deviations which would be less than the Minimum Standards for any group must be approved in writing to the Board of Trustees of the Illinois Foundation for Medical Care.

J. Custodial care for psychiatric patients.

XV. Other Possible Exclusions and Limits

- A. Normal maternity
- B. Donor expenses in transplant surgery.

XVI. Recommended Possible Additional Coverage

- A. Physical examinations and/or multi-phasic screening examinations, by or under the direction of a physician.

Age	
6 mos. to 17 yrs.	— annually
17 yrs. to 35 yrs.	— every 3 years
35 yrs. to 50 yrs.	— every 2 years
50 yrs. and up	— every year

Board of Trustees, Apr. 1-5, 1975.

Statement of Understanding

(between patient and physician)

I agree that the determination of professional services to be rendered by my doctor and the fees to compensate him for these services are matters concerning my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services, notwithstanding any contract I may have with any third party (be it an insurance company, employer, union, government, or the like). Neither my doctor nor I will permit any third

party to determine what medical services I need or what fees the doctor should receive in return for these services. Any agreement that either of us may have with any third party shall not affect our doctor-patient relationship and the decisions relating to medical care and fees. Neither my doctor nor I, as his patient, are in any way bound by any contract the other may have with any third party.

ISMS HOUSE OF DELEGATES

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25 E. Washington, Chicago 60602
Vice Speaker of the House—Robert P. Johnson
108 Maple Grove, Springfield 62707

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675 W. Central Rd., Arlington Heights 60005 ..1979
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Alfred Faber
3851 N. Mission Hills Road, Apt. 401,
Northbrook 600621980
Robert T. Fox
2136 Robincrest Lane, Glenview 600251979

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6429 North Avenue, Oak Park 603021978
Joseph Sherrick
303 E. Superior, Chicago 606111980
Herman Wing
155 N. Harbor Dr., Chicago 606011979
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723 N. 2nd St., Chiclicothe 615231979
5th District—Paul F. Mahon
Dept. Radiology, St. John's Hospital
Springfield 627011979
6th District—Robert R. Hartman
1515A W. Walnut, Jacksonville 626501978
7th District—Alfred J. Kiesel
1 Powers Lane PL, Decatur 625221979
8th District—James Laidlaw
104 W. Clark, Champaign 618201979
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203 N. Vine, Harrisburg 629461978
10th District—Julian W. Buser
6600 W. Main, Belleville 622231978
11th District—Kenneth A. Hurst
52 Bunting Lane, Naperville 605401980
12th District—P. John Seward
2400 N. Rockton, Rockford 611011980
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707 Fairbanks Court, Chicago 606111978

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A complete listing of delegates and alternates to the ISMS House appears in the convention program.

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Past Presidents

J. Ernest Breed1971
Everett P. Coleman1945-1946
Edward W. Cannady1970
Newton DuPuy1968
Harlan English1964
Edwin S. Hamilton1962
H. Close Hesseltine1961
J. M. Ingalls1976
Charles J. Jannings, III1972
Frank J. Jirka, Jr.1973
Fredric D. Lake1975
Willis I. Lewis1954
Burtis E. Montgomery1966
Edward A. Piszczek1965
Caesar Portes1967
Willard C. Scrivner1974
Joseph H. Skom1977
Leo P. A. Sweeney1953
Phillip G. Thomsen1969
Arkel M. Vaughn1955

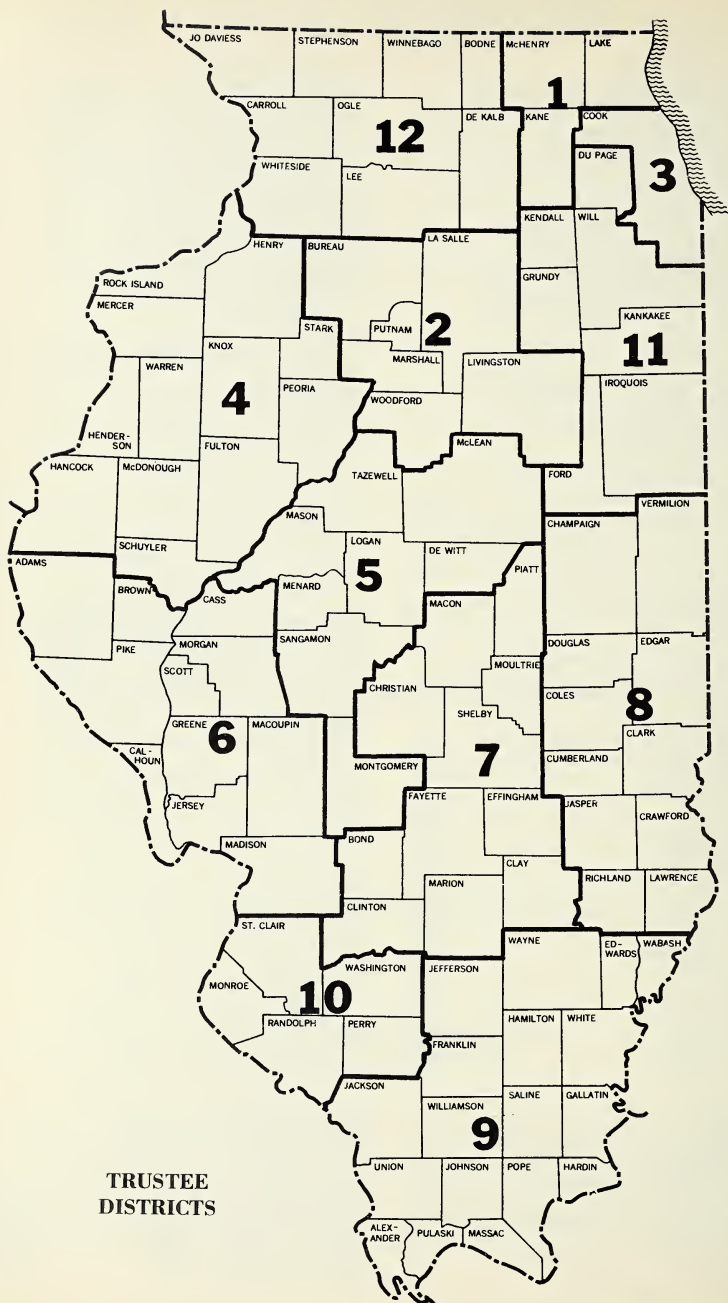
Past Trustees

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Walter C. Bornemeier
Chicago, Trustee of the 3rd District
Herbert Dexheimer
Belleville, Trustee of the 10th District
Willard W. Fullerton
Sparta, Trustee of the 10th District
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Decatur, Trustee of the 7th District

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Bloomington, Trustee of the 5th District
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Glen Ellyn, Trustee of the 11th District
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Mt. Vernon, Trustee of the 9th District
Warren W. Young
Indiana, Trustee of the 3rd District
Paul P. Youngberg
Moline, Trustee of the 4th District

Past Speakers

Walter C. Bornemeier, Chicago1961-1964
Andrew J. Brislen, Chicago1974-1975
Edward W. Cannady, Belleville1964-1967
Maurice M. Hoenlgen, Chicago1967-1970
James A. McDonald, Geneva1976-1977
Paul W. Sunderland, Gibson City1970-1973



TRUSTEE DISTRICTS

TRUSTEE DISTRICT COMMITTEES

First District

John J. Ring, Mundelein, *Trustee*
 Counties of Kane, Lake, McHenry

ETHICAL RELATIONS COMMITTEE

	TERM EXPIRES
David Clark, Aurora	1978
Emanuel Herzon, Elgin	1978
Gerald Liesen, St. Charles	1979
A. M. Rosetti, McHenry	1980
David Helberg, Waukegan	1978
Eugene Pitts, Waukegan	1978
James Pritchard, Geneva	1978
Peter Vinciguerra, Libertyville	1978

Second District

Allan L. Goslin, Streator, *Trustee*
 Counties of Bureau, LaSalle, Livingston, Marshall, Putnam, Woodford

ETHICAL RELATIONS COMMITTEE

	TERM EXPIRES
William Erkonen, Streator, <i>Chairman</i>	1980
Julius Kowalski, Princeton	1980
Karl T. Deterding, Pontiac	1980

PEER REVIEW COMMITTEE

Louis Tarsinos, Princeton, <i>Chairman</i>	1979
James B. Aplington, LaSalle	1979
Francis J. Brennan, Utica	1979
Silvio Davito, Spring Valley	1979
Bernard J. Doyle, LaSalle	1979
William Ehling, Streator	1980
P. Lymberopoulos, Princeton	1979
Rowland Musick, Mendota	1979
Theodore Mauger, Chatsworth	1978
Theodore W. Wagenknecht, Streator	1979

Third District

Herschel Browns, Evanston, *Trustee*
 Alfred Clementi, Arlington Heights, *Trustee*
 Audley F. Connor, Jr., Chicago, *Trustee*
 Alfred J. Faber, Glenview, *Trustee*
 Robert T. Fox, Glenview, *Trustee*
 Henrietta Herbolzheimer, Chicago, *Trustee*
 Lawrence L. Hirsch, Chicago, *Trustee*
 Eugene T. Hoban, Oak Park, *Trustee*
 Joseph C. Sherrick, Chicago, *Trustee*
 Herman Wing, Chicago, *Trustee*

Fourth District

Fred Z. White, Chicillothe, *Trustee*
 Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Warren

ETHICAL RELATIONS COMMITTEE

	TERM EXPIRES
Richard Icenogle, Roseville, <i>Chairman</i>	1980
John Bowman, Abingdon	1979
George Burke, Rock Island	1978

PEER REVIEW COMMITTEE

Donald Dexter, Macomb, <i>Chairman</i>	1980
William Daugherty, Moline	1978
Jackson K. Erffmeyer, Galesburg	1979
G. W. Geibelhausen, Peoria	1978
James C. Parsons, Geneseo	1979
Clarence Ward, Peoria	1978

Fifth District

Paul F. Mahon, Springfield, *Trustee*
 Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon, Tazewell

ETHICAL RELATIONS COMMITTEE

	TERM EXPIRES
Richard H. Suhs, Springfield, <i>Chairman</i>	1980
Jack Means, Mason City	1978
A. L. Van Ness, Bloomington	1979

PEER REVIEW COMMITTEE

James Borgerson, Mt. Pulaski, <i>Chairman</i>	1980
Robert Price, Bloomington, <i>Co-Chairman</i>	1980
George Irwin, Bloomington	1979
Paul Lafata, Springfield	1980
John G. Meyer, Springfield	1978
Alton J. Morris, Springfield	1979
Robert B. Perry, Lincoln	1979
Robert Schaefer, Petersburg	1978
James Weimer, Pekin	1979

Sixth District

Robert R. Hartman, Jacksonville, *Trustee*
 Counties of Adams, Brown, Calhoun, Cass, Green, Jersey, Macoupin Madison, Morgan, Pike, Scott

ETHICAL RELATIONS COMMITTEE

	TERM EXPIRES
Newton DuPuy, Quincy, <i>Chairman</i>	1980
Bernard Baalman, Hardin	1978
Edward K. DuVivier, Alton	1980
Joseph J. Grandone, Gillespie	1980

PEER REVIEW COMMITTEE

James Reid, Greenfield, <i>Chairman</i>	1980
Walter Stevenson III, Quincy, <i>Co-Chairman</i>	1980
E. C. Bone, Jacksonville	1979
Robert England, Carlinville	1978
Robert C. Murphy, Quincy	1979
B. Frank Norbury, Jacksonville	1978
Edward Ragsdale, Alton	1980
James Sutherland, Quincy	1980

Seventh District

Alfred J. Kiessel, Decatur, *Trustee*
 Counties of Bond, Christian, Clay, Clinton, Effingham,
 Fayette, Macon, Marion, Moultrie, Piatt, Shelby

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
C. R. Daisy, Greenville, <i>Chairman</i>	1978
D. M. Rames, Vandalia	1979
Charles Stanley, Decatur	1979

PEER REVIEW COMMITTEE

Stanley Moore, Vandalia, <i>Chairman</i>	1979
M. K. Kaufman, Greenville	1980
H. Gale Zacheis, Decatur	1980
Walter P. Plassman, Centralia	1979

Eighth District

James Laidlaw, Champaign, *Trustee*
 Counties of Champaign, Clark, Coles, Crawford, Cumber-
 land, Douglas, Edgar, Jasper, Lawrence, Richland, Ver-
 million

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
Mack W. Hollowell, Charleston, <i>Chairman</i>	1980
James H. Pass, Olney	1978
Alan M. Taylor, Danville	1979

PEER REVIEW COMMITTEE

E. T. Baumgart, Danville, <i>Chairman</i>	1980
George T. Michell, Marshall	1978
Michael Murray, Olney	1979
George Perlstein, Champaign	1979
C. E. Ramsey, Charleston	1979
Gordon Sprague, Paris	1979

Ninth District

Wayren D. Tuttle, Harrisburg, *Trustee*
 Counties of Alexander, Edwards, Franklin, Gallatin, Ham-
 iltion, Hardin, Jackson, Jefferson, Johnson, Masac, Pope,
 Pulaski, Saline, Union, Wabash, Wayne, White, Wil-
 liamson.

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
Alex Goldstein, Harrisburg, <i>Chairman</i>	1979
Eli Borkon, Carbondale	1980
Robert Rader, Anna	1980

PEER REVIEW COMMITTEE

C. J. Jannings, III, Fairfield, <i>Chairman</i>	1979
Philip D. Boren, Carmi	1980
Herbert V. Fine, Carterville	1978
James Heersma, Mt. Vernon	1979
Harty L. Lewis, Benton	1978
Charles K. Wells, Mt. Vernon	1979

Tenth District

Julian W. Buser, Belleville, *Trustee*
 Counties of Monroe, Perry, Randolph, St. Clair, Washing-
 ton

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
H. P. Dexheimer, Belleville, <i>Chairman</i>	1979
Roy Kenney, E. St. Louis	1979
Edilberto Maglasang, Columbia	1979
Wm. A. Simmons, Belleville	1979

PEER REVIEW COMMITTEE

William H. Walton, Belleville, <i>Chairman</i>	1978
Benjamin Arenas, Belleville	1979
Ted Bryan, Belleville	1979
R. W. Jost, Waterloo	1978
R. E. Schettler, Red Bud	1980

Eleventh District

Kenneth Hurst, Naperville, *Trustee*
 Counties of DuPage, Ford, Grundy, Iroquois, Kankakee,
 Kendall, Will

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
James Ryan, Kankakee, <i>Chairman</i>	1978
Lawrence D. Lee, Manhattan	1979
Merle Otto, Frankfurt	1979
William C. Perkins, West Chicago	1979

PEER REVIEW COMMITTEE

James Campbell, Wheaton, <i>Chairman</i>	1978
James E. Dailey, Watseka	1978
James Lambert, Joliet	1979
Guy Pandola, Joliet	1978
A. G. Parkhurst, Kankakee	1980
W. H. Brill, Oswego	1980
Charles G. White, Naperville	1979

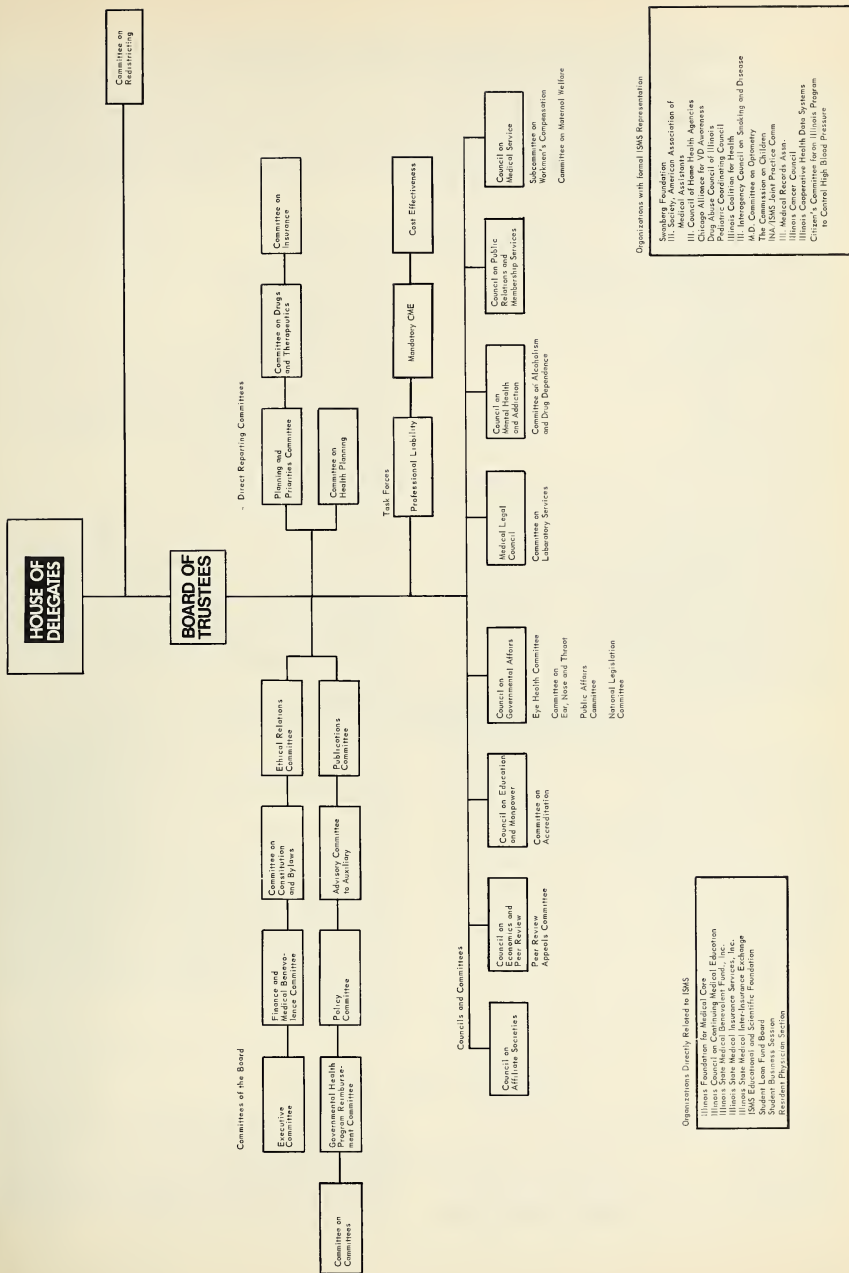
Twelfth District

P. John Seward, Rockford, *Trustee*
 Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle,
 Stephenson, Whiteside, Winnebago

	TERM EXPIRES
ETHICAL RELATIONS COMMITTEE	
John H. Steinkamp, Belvidere, <i>Chairman</i>	1978

PEER REVIEW COMMITTEE

Keith Wrage, Rockford, <i>Chairman</i>	1980
Frank Luedtke, DeKalb	1978
John L. Clark, Freeport	1979



Councils of the Illinois State Medical Society

Councils of the Illinois State Medical Society are appointed by the Chairman of the Board of Trustees subject to approval of the Board of Trustees. The councils are composed of such members as are necessary to accomplish the purposes of the council. Some committees are composed of members of the Board of Trustees and are designated Board Committees. Some free standing committees may report directly to the board and may not be assigned to a council. Task Forces are established to address a particular problem or concern which crosses areas of responsibility of the several councils. The task forces report directly to the board, as do representatives to various other agencies. The President, President-Elect, Speaker of the House, and Chairman of the Board are, by virtue of their office, ex-officio members of all groups.

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 Robert Betasso, Ottawa
 Ill. Chap., Amer. Coll. of Surgeons
 Ivan Ciric, Evanston
 Ill. Neurosurgical Society
 John Coleman, Chicago
 Ill. Society of Internal Medicine
 Dean Farley, Riverside
 Ill. OB-GYN Society
 Jack L. Gibbs, Canton
 Ill. Surgical Society
 John P. Harrod Jr., Chicago
 Ill. Section, Amer. College of OB-GYN
 B. Jay Hill, Chicago
 Ill. Radiological Society
 Gerald G. Hoffman, Lake Forest
 Ill. Society of Pathology
 Anthony D. Ivankovich, Glenview
 Ill. Society of Anesthesiologists
 Martin J. Kaplan, Highland Park
 The Allergy & Clinical Immunology Soc. of Ill.
 M. Barry Kirschenbaum, Chicago
 Ill. Dermatological Society
 Robert J. Kramer, Joliet

Ill. Soc. of Ophthalmology & Otolaryngology
 James F. Kurtz, LaGrange
 Ill. Orthopaedic Soc.
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 Chicago Urological Soc.
 Robert C. Muehrcke, Oak Park
 Ill. Chap., Amer. College of Physicians
 Joseph Paxhia, DesPlaines
 Ill. Association of Ophthalmology
 Alan B. Spacone, Glen Ellyn
 Ill. Chapter, Amer. Coll. of Emergency Physicians
 Eugene Diamond, Chicago (*Pres.*)
 American Academy of Pediatrics
 Jerome S. Beigler, Chicago (*Pres.*)
 Ill. Psychiatric Society

CONSULTANT:

Paul Mahon, Springfield

STAFF: Division of Health Care Delivery and Field Services

Responsibilities and Purposes:

To improve communication and provide liaison with the specialty societies; provide specialty consultation to other ISMS councils and committees; and to serve as a resource unit to ISMS on advances in the medical specialties.

COUNCIL ON ECONOMICS AND PEER REVIEW

A. Beaumont Johnson, Elgin, *Chairman*
 Peter A. Brusca, Carol Stream
 James P. Durham, Benton
 William A. Hutchison, Chicago
 Martin P. Meisenheimer, Arlington Heights
 Michael E. Murray, Olney
 Herbert Natof, Highland Park
 Roger N. Pesch, Wheaton
 Frank C. Sedlak, Riverside
 Joseph Silverstein, Wilmette
 Alex Spadoni, Joliet
 Fred A. Tworoger, Chicago
 Ben Williams, Urbana

ILL. CLINIC MGRS. ASSOC. REP.

James R. Jepson, Aurora (without vote)

CONSULTANTS

Allan L. Goslin, Streator
 Eugene P. Johnson, Casey

STUDENT

Juan Asensio, Chicago

STAFF: Division of Health Care Delivery and Field Services

Responsibilities and Purposes:

The Council on Economics & Peer Review shall concern itself with: 1) relations with the health insurance industry and prepayment plans; 2) fees and fee adjudication as promulgated by the ISMS; 3) health care cost and utilization; 4) new modes of health care delivery (prepaid programs, surgicenters, etc.).

Committee:

Peer Review Appeals

PEER REVIEW APPEALS COMMITTEE

Michael E. Murray, *Chairman*
 Martin P. Meisenheimer
 Herbert Natof
 Frank C. Sedlak
 Ben Williams

STAFF: Division of Health Care Delivery and Field Services

Responsibilities and Purposes:

The Peer Review Appeals Committee serves as the appellate body for peer review in the state. It considers cases being appealed from local or district Peer Review committees involving quality and cost of medical care. The committee also serves as liaison to local peer review committees and offers its assistance whenever requested.

COUNCIL ON EDUCATION AND MANPOWER

Eugene T. Leonard, Rockford, *Chairman*
Dean R. Bordeaux, Peoria
Milda Budrys, Chicago
Charles F. Eddingfield, Carthage
William L. Jackson, Urbana
Charles T. McHugh, Chicago
Joseph P. McKay, Elmhurst
David Roxe, Chicago
Eugene J. Scherba, Dolton
Ralph Wynn, River Forest
Vern L. Zech, Waukegan
Simon Zivin, Lincolnwood

STUDENT

John P. Johnson (Loyola), Forest Park

CONSULTANTS

Lawrence Hirsch, Chicago
Henrietta Herbolzheimer, Chicago
William M. Lees, Lincolnwood

STAFF: Division of Education, Manpower and
Convention Services

Responsibilities and Purposes:

The Council on Education and Manpower shall study and evaluate all phases of medical education, including the development of programs by and for ISMS, and review programs for paramedical personnel. It shall carry to the deans of medical schools recommendations from the viewpoint of the practicing physician. It shall evaluate available postgraduate programs, advise the Illinois Dept. of R&E, and review hospital oriented education programs. Liaison shall be maintained with medical students and physicians-in-training and with loan programs for medical students. Activities regarding physician distribution and retention shall also be within the scope of the Council, as well as medical licensure as it relates to education.

Committee:

Accreditation

COMMITTEE ON ACCREDITATION

Dean R. Bordeaux, Peoria, *Chairman*
Philip D. Anderson, Chicago
H. Close Hesselstine, Chicago
Rex O. McMorris, Peoria
Julius S. Newman, Aurora

STAFF: Division of Education, Manpower and
Convention Services

Responsibilities and Purposes:

To review survey reports of institutions which have applied for accredited status and grant accreditation to promote Continuing Medical Education activities; to provide liaison with the Illinois Council on Continuing Medical Education.

GOVERNMENTAL AFFAIRS COUNCIL

Tassos Nassos, Chicago, *Chairman*
Donald Aaronson, Chicago
Theodore Bryan, Belleville
George Burke, Rock Island
Howard Burkhead, Evanston
James Cavanaugh, Jr., Winnetka
David C. Christy, Watseka
David Clark, Aurora
Edwin Falloon, Evergreen Park
Don Hinderliter, Rochelle
Frank J. Kresca, Champaign
Richard N. Rovner, Chicago
Michael Victor, D.O., Buffalo Grove

ILL. CLINIC MGRS. ASSOC. REP.
Howard Cloys, Chicago Heights

AUXILIARY REPRESENTATIVE

Mrs. Byron Weisbaum, Springfield

STUDENT REPRESENTATIVE

Daniel Shirley, Maywood

CONSULTANTS

Alfred J. Faber
James Laidlaw
Warren D. Tuttle
Pam Taylor
Theodore Grevas

STAFF: Governmental Affairs Division

Responsibilities and Purposes:

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens of Illinois and the practice of medicine in Illinois.
2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois.
3. Co-operate with the AMA in similar programs.
4. Develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

Committees:

Ear, Nose, and Throat
Eye Health
Public Affairs
National Legislation Committee

AD HOC EAR, NOSE, AND THROAT COMMITTEE

Jack D. Clemis, Chicago, *Chairman*
John Ballenger, Winnetka
Irwin Horwitz, Chicago

Felix J. Lownik, Freeport
Ralph Nauntun, Chicago
Burton Soboroff, Chicago

AD HOC EYE HEALTH COMMITTEE

Frank J. Kresca, Champaign, *Chairman*
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Burton Russman, Chicago

Frank Snell, Decatur
Robert W. Webb, East Alton

NATIONAL LEGISLATION COMMITTEE

Howard Burkhead, Evanston, *Chairman*
Edwin L. Falloon, Evergreen Park
Frank J. Jirka, Jr., River Forest
Joseph R. O'Donnell, Glen Ellyn
Jerry Ramunis, Victoria

CONSULTANTS
Alfred J. Faber
Pam Taylor
Willard Scrivner

PUBLIC AFFAIRS COMMITTEE

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James H. Andersen, Oak Brook
Louis Dondanville, Moline
J. M. Ingalls, Paris
Jesse E. Jacobs, Arlington Heights
Alex H. Kaz, Harvey
Earl Klaren, Libertyville
George T. Mitchell, Marshall
Edward Ragsdale, Godfrey

Albert W. Ray, Jr., Joliet
A. E. Steer, Springfield
William Wehrmacher, Chicago
AUXILIARY REPRESENTATIVE
Mrs. John Ovitz, Jr., Sycamore
CONSULTANTS
Pam Taylor, Danville
Theodore Grevas, Rock Island

MEDICAL LEGAL COUNCIL

Eugene Vickery, Lena, *Chairman*
Earl Suckow, Mt. Prospect
Charles Wells, Mt. Vernon
Leonard Kluft, Joliet
Raymond Dieter, Glen Ellyn
Michael Murphy, Belleville
David Petty, Chicago

CONSULTANTS
Herman Wing, Chicago
James Habegger, Aurora
Frank Stuart, Chicago
Alfred Kiessel, Decatur

STUDENT REPRESENTATIVE
David Hopp, Chicago

STAFF: Division of Publications, Medical-Legal and
Mental Health

Responsibilities and Purposes:

The Medical Legal Council shall cooperate with all organizations interested in medico-legal problems in order

to educate members of the profession in medico-legal affairs.

This council shall maintain liaison with the Illinois Bar Association and cooperate with the judiciary in both federal and state courts within the state of Illinois. It shall, when requested by the court, activate the Impartial Medical Testimony panel. The stated objective of the panel is to provide consultations, judgment and opinions in situations in which there is unusual controversy or wide divergence of medical opinion.

The council shall study recommendations for methods of elevating and maintaining the standards of medical laboratories in Illinois. In addition, the council shall be concerned with standards of practice, licensure and quackery.

Committees:

Impartial Medical Testimony
Laboratory Services

COMMITTEE ON LABORATORY SERVICES

Earl Suckow, Mt. Prospect, *Chairman*
Bernard Stodsky, Chicago
Robert Carrara, Geneva
Joseph O. Dean, Peoria
Newell Braatelein, Moline
J. Robert Thompson, Oak Park

CONSULTANT:
Alfred Kiessel, Decatur

STAFF: Division of Publications, Medical-Legal and
Mental Health

Responsibilities and Purposes:

The committee shall monitor methods of elevating and maintaining the standards of medical laboratories in Illinois, encourage the use of medical diagnostic laboratories supervised by duly qualified physicians and encourage each county and district to establish evaluation committees. It will cooperate with various state agencies in promoting a safe, adequate blood supply for the state.

COUNCIL ON MENTAL HEALTH AND ADDICTION

Patrick Staunton, Oak Park, *Chairman*
Edward Senay, Chicago (*IPS Liaison*)
Warren R. Dammers, Harrisburg
Anthony Busch, Belleville
Marvin R. DeHaan, Wayne
Thomas E. Kirts, DeKalb
Geoffrey L. Levy, Arlington Heights
Kermet Mehlinger, Chicago (*Alcoholism & Drug Dependence*)
Arthur R. Traugott, Urbana
James West, Evergreen Park
(*Alcoholism & Drug Dependence*)
Arthur Woloshin, Highland Park

CONSULTANTS:

Joseph Skom, Chicago
Robert deVito, Chicago, *Director*
Illinois Dept. of Mental Health and
Developmental Disabilities

STUDENT REPRESENTATIVE

William Ketcherside, Chicago

STAFF: Division of Publications, Medical-Legal and
Mental Health

Responsibilities and Purposes:

This council shall serve as a source of information on mental health matters for ISMS, evaluate information and make recommendations to the Board of Trustees on positions ISMS should take on issues in this area, and cooperate with institutions, voluntary health agencies, state agencies and professional associations in disseminating information on mental health, alcoholism and drug abuse.

The council shall be on the alert for misleading or fallacious programs and information and recommend appropriate action. It shall also be concerned with reviewing legislation related to the field of mental health, alcoholism, drug abuse, and hazardous substances.

Committee:

Alcoholism and Drug Dependence

COMMITTEE ON ALCOHOLISM AND DRUG DEPENDENCE

James West, Evergreen Park, *Co-Chairman*
Kermit Mehlinger, Chicago, *Co-Chairman*
Albert W. Ray, Joliet
George Stanton, Chicago
R. Schuller, Kankakee
W. David Steed, Oak Park
Wayne Spenader, Sublette
Robert Rivers, Geneva
Edward Senay, Chicago
Lee Gladstone, Chicago

CONSULTANTS:

Vince Franco, DDC, Chicago
Msgr. Ignatius McDermott, Chicago
Robert McMahon, DACI, Chicago
Joseph Levy, Ed. D., Un. of Ill., Chicago
Sally Lipscomb, R.N., Chicago
J. Roalda Alderman, Div. of Alcoholism, Chicago
Janice Gomien, IADDA, Springfield

STAFF: Division of Publications, Medical-Legal and
Mental Health

Responsibilities and Purposes:

The Committee shall work closely with public and private agencies on projects aimed at eliminating the misuse of alcohol and drugs. The committee's functions will include: (1) study, research and dissemination of educational information on drugs and alcohol to members of the medical profession; (2) cooperate in the dissemination of information on the causes, prevention, diagnosis and treatment of alcoholism and drug dependence to the medical profession and to the public; (3) recommend acceptable measures for control of distribution and disposal of drugs and hazardous substances, exclusive of radiation products, and (4) cooperate with official and non-official agencies in all matters pertaining to this subject.

COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Mack W. Hollowell, Charleston, *Chairman*
Robert Boxer, Skokie
Robert Hamilton, Chicago
Alan Taylor, Danville
Peter Vinciguerra, Libertyville

CONSULTANTS:

Herschel Browns, Chicago
Eugene Hoban, Oak Park

STUDENT MEMBER

Jerome Cohen, Chicago

AUXILIARY REPRESENTATIVE

Mrs. Harlan Failor, Champaign

STAFF: Division of Public Relations and
Membership Services

Responsibilities and Purposes:

The Council on Public Relations and Membership Services shall plan and execute programs designed to enhance the relationship between the media, clergy, general public and medical profession. Included shall be health education and socio-economic programs believed to be in the best interest of the profession as well as the general public. The council shall be responsible for new member orientation, exhibits and public service programming.

COUNCIL ON MEDICAL SERVICE

Glen Tomlinson, Lincoln, *Chairman*
Helen C. Bonbrest, Chicago
Joan Cummings, Hines
William W. Curtis, Springfield
Thomas H. Davison, Chicago
Edward A. Galapeaux, Oak Lawn
Lee Johnson, Litchfield
A. Everett Joslyn, River Forest
Max Klinghoffer, Elmhurst
David B. Littman, Highland Park
Shirley A. Roy, Chicago
Edward Ryan, Palos Heights
Edward F. Wilt, Jr., McHenry
Joseph D. Winterhalter, Rockford

CONSULTANTS:

Paul Q. Peterson, M.D., Director, IDPH, Springfield
Henrietta Herbolzheimer, Chicago
Kenneth A. Hurst, Naperville

AUXILIARY REPRESENTATIVE
Mts. Harold Keegan, Kankakee

STUDENT REPRESENTATIVE
Daniel Eisenberg, Chicago

STAFF: Division of Health Care Delivery and Field Services

Responsibilities and Purposes:

The Council initiates and implements programs related to health education, medical facilities and services. It also maintains liaison with other health care organizations involved with vocational rehabilitation, Workmen's Compensation, aging, the poor, rural areas and emergency medical services.

In addition, the Council and its Committee on Maternal Welfare cooperate with the Illinois Department of Public Health in the maintenance, protection and improvement of the health of the people of Illinois.

Committee:

Maternal Welfare

COMMITTEE ON MATERNAL WELFARE

DISTRICTS MEMBERS AND ALTERNATES

(*alternates in italics*)

William W. Curtis, Springfield, *Chairman*

1. Hugh C. Falls, Lake Forest

Gan L. Tjiook, Geneva

2. William J. Farley, Peru

3. Alex Kaz, Harvey

Charles F. Kramer, Glenwood

4. Ralph Gibson, Peoria

Raoul E. Reinertsen, Canton

5. William W. Curtis, Springfield

Robert Maletich, Springfield

6. Richard D. Yoder, Alton

Donald E. Hardbeck, Alton

7. Paul A. Raber, Decatur

Hubert Magill, Decatur

8. J. Roger Powell, Urbana
- John C. Mason, Jr., Danville*
9. Allan G. Bennett, Carbondale
- William B. Skaggs, Harrisburg*
10. Arthur A. Smith, O'Fallon
- Ferdinand J. Mueller, Belleville*
11. John J. McLaughlin, Joliet
- Charles P. Westfall, Elmhurst*
12. John F. Hubbard, Sterling

CONSULTANTS:

Robert R. Hartman, Jacksonville
John Louis, Lake Forest
Augusta Webster, Chicago

STAFF: Health Care Delivery and Field Services

Committees of the Board of Trustees

COMMITTEE ON CONSTITUTION AND BYLAWS

James Laidlaw, Champaign, *Chairman*

David S. Fox, Chicago

John J. Ring, Mundelein

Cyril C. Wiggishoff, Chicago

Herman Wing, Chicago

CONSULTANT: Legal Counsel

STAFF: Division of Education, Manpower and
Convention Services

Responsibilities and Purposes:

The Committee on Constitution & Bylaws shall:

- 1) Receive from individual members, county societies, committees, the Board of Trustees and the House of Delegates, all suggestions and proposals for modification of the Constitution & Bylaws;
- 2) Prepare for the consideration of the House of Delegates, all changes in the Constitution & Bylaws; and
- 3) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

ETHICAL RELATIONS COMMITTEE

Eugene T. Hoban, Oak Park, *Chairman*
Julian W. Buser, Belleville
Alfred J. Faber, Northbrook
Henrietta Herbolsheimer, Chicago
William M. Lees, Lincolnwood
Paul F. Mahon, Springfield
Warren D. Tuttle, Harrisburg

STAFF: Division of Administration

Responsibilities and Purposes:

The responsibilities and purposes of this committee are outlined in CHAPTER XI, DISCIPLINE, Part 2 *Illinois State Medical Society Procedures*.

Section 1, Illinois State Medical Society Ethical Relations Committee. The Board of Trustees shall appoint from its members an Ethical Relations Committee to review decisions of the component society involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and By-laws of the Illinois State Medical Society or its component societies and charges of misconduct of members of the Society.

Section 2, Appeals from Component Society Verdicts. Appeals received by the Illinois State Medical Society Board of Trustees shall be referred to the Ethical Relations Committee of the Board for review. (Appeals must be accompanied by a comprehensive stenographic record, tape

recording, or its equivalent, of the entire proceedings taken before the component county society together with all exhibits submitted in evidence. If the component county society fails to provide the record on appeal, the Ethical Relations Committee of Illinois State Medical Society shall find the accused "not guilty.") The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

Section 3, Verdict. The Ethical Relations Committee of the Board of Trustees shall hear any new and pertinent evidence any interested party desires to present, and at the conclusion of the trial, the decision of the component society shall be affirmed, overruled or sent back to the component society for reconsideration.

Section 4, Notification and right of appeal. The secretary of the Society shall notify the defendant and the secretary of the component society wherein the defendant holds membership, of the action of the Board. In the event of a decision against the accused he shall have the right to appeal the decision to the Judicial Council of the American Medical Association and the secretary of the State Society shall so notify the accused of this right.

EXECUTIVE COMMITTEE

Robert T. Fox, Glenview, *Chairman*
Alfred Clementi, Arlington Hts.
David S. Fox, Chicago
Theodore Grevas, Rock Island
Eugene P. Johnson, Casey
Joseph H. Skom, Chicago
Fred Z. White, Chilliocthe
George T. Wilkins, Granite City

EX-OFFICIO (without vote):
Jack L. Gibbs, Canton

BY INVITATION (without vote)
Cyril C. Wiggishoff, Chicago

STAFF: Division of Administration

Responsibilities and Purposes:

The Executive Committee shall consist of the president, the president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical

Benevolence Committee, the chairman of the Policy Committee, the secretary-treasurer, the trustee-at-large and the immediate past chairman of the Board provided he is still a Trustee.

The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, shall serve as an ex-officio member of the Executive Committee without vote.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

(Bylaws, Chapter IX, Part 4, Section 2, Paragraph A.)

FINANCE COMMITTEE AND MEDICAL BENEVOLENCE

Alfred Clementi, Arlington Heights, *Chairman*
Herschel Browns, Chicago
Eugene P. Johnson, Casey
P. John Seward, Rockford

STAFF: Division of Administration

Responsibilities and Purposes:

The Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop a budget for the fiscal year for approval of the Board through the Executive Committee. It shall supervise the financial transactions of the Society. It shall make recommendations to

the Board for the control and investment of the funds of the Illinois State Medical Society.

The Finance Committee shall also be responsible for the society's Medical Benevolence Program and shall:

1. Examine applications for financial assistance and determine eligibility.
2. Keep the names of the beneficiaries confidential and known only to the committee.
3. Determine the allotment for each recipient.
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

COMMITTEE ON GOVERNMENTAL HEALTH PROGRAM REIMBURSEMENT

Robert R. Hartman, Jacksonville, *Chairman*
Herschel Browns, Chicago
Audley F. Connor, Jr., Chicago
Allan L. Goslin, Streator
P. John Seward, Rockford

ILL. CLINIC MGRS. ASSOC. REP.
Mr. Sherwin Sern, McHenry

STAFF: Division of Health Care Delivery and Field Services

Responsibilities and Purposes:

The responsibilities of the Committee on Governmental Health Program Reimbursement will be to consider all problems of physician reimbursement by the government health programs—Medicare, Medicaid, MEDICHER and CHAMPUS. The Committee serves on a stand-by basis.

POLICY COMMITTEE

Fred Z. White, Chillicothe, *Chairman*
Alfred J. Kiessel, Decatur
Joseph C. Sherrick, Chicago
STAFF: Division of Education, Manpower and
Convention Services

Responsibilities and Purposes:

The Policy Committee shall consist of three members

of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

PUBLICATIONS COMMITTEE

Lawrence L. Hirsch, Chicago, *Chairman*
Alfred Kiessel, Decatur
Herman Wing, Chicago
Robert P. Johnson, Springfield
Kenneth A. Hurst, Naperville

CONSULTANT:

Jacob E. Reisch, Springfield

STAFF: Division of Publications, Medical-Legal and
Mental Health

Responsibilities and Purposes:

The Publications Committee shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal* and other Society publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates and standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the *Journal*.

The committee may establish such editorial consultation groups as necessary to assist in development of clinical articles and shall authorize all regular and special features.

ADVISORY COMMITTEE TO ISMS AUXILIARY

Joseph H. Skom, Chicago, *Chairman*
Robert T. Fox, Glenview
George T. Wilkins, Jr., Granite City

STAFF: Division of Administration

Responsibilities and Purposes:

The committee shall consist of the immediate past president as chairman, the president, and the chairman of the Board. The committee shall provide advice and assistance to the president of the ISMS Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members.

COMMITTEE ON COMMITTEES

Allan L. Goslin, Streator, *Chairman*
Robert R. Hartman, Jacksonville
Eugene T. Hoban, Oak Park

STAFF: Division of Education, Manpower and
Convention Services

Responsibilities and Purposes:

The Committee on Committees shall consist of three

members of the Board appointed by the chairman. It shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board.

The committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

Direct Reporting Committees

All Board Committees previously noted consist of members of the Board of Trustees. As such they function within the activities of the Board.

Direct Reporting Committees are groups deemed necessary by the Board of Trustees and are created by the Board to meet specific challenges. These committees may function with, and under, a council, or may report directly to the Board of Trustees.

While other select committees may be formed from time to time, at the time of publication the following groups had been established.

COMMITTEE ON HEALTH PLANNING

B. Smith Hopkins, Urbana, *Chairman*
T. C. Bunting, Pittsfield
Robert D. Dooley, Oak Brook
Charles J. Jannings, III, Fairfield
Boyd E. McCracken, Greenville
Edward A. Newman, Chicago
Anthony Raimondi, Chicago

CONSULTANTS:

Henrietta Herbolzheimer, Chicago
Alfred J. Kiessel, Decatur
Fred Z. White, Chillicothe

STAFF: Division of Health Care Delivery and Field Services

Responsibilities and Purposes:

The Committee has the responsibility of keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The Committee maintains ongoing liaison with the State Planning Agency, the Statewide Health Coordinating Council, the Health Facilities Planning Board and the local areawide health planning agencies.

COMMITTEE ON DRUGS AND THERAPEUTICS

Vincent A. Costanzo, Jr., Chicago, *Chairman*
Bernard J. Baltes, Lincolnwood
Norman J. Ehrlich, Chicago
John S. Hyde, Oak Park
Richard H. Suhs, Springfield

CONSULTANT:

Louis Gdalmann, R.Ph., Oak Brook

STAFF: Division of Education, Manpower and Convention Services

Responsibilities and Purposes:

The Committee shall meet periodically to refine the drug list contained in the Drug Manual. It shall work with the Illinois Department of Public Aid in an effort to keep the Drug Manual current and effective. When suggestions and comments from the members are submitted to the committee, it shall review them and present them to the Department of Public Aid when necessary. The committee shall also consider other drug matters affecting the policy of the medical society.

COMMITTEE ON INSURANCE

B. Franklin Lounsbury, Chicago, *Chairman*
William A. Henry, Springfield
Lawrence Knox, Olney
James Rybak, Lincolnshire

CONSULTANTS:

Alfred D. Clementi, Arlington Heights
Theodore Grevas, Rock Island

STAFF: Division of Education, Manpower and Convention Services

Responsibilities and Purposes:

The Committee on Insurance will review society-sponsored insurance programs, which are currently the Tax Qualified Retirement Program (Keogh Plan), Retirement Investment Program, Group Disability Program, Business Overhead Expense Insurance, Group Major Medical Program, Hospital Benefit Program, and Group Life Insurance. The committee will study these plans, make suggestions for changes, additions and cancellation of policies, and investigate other insurance programs that may benefit society members.

PLANNING AND PRIORITIES COMMITTEE

David S. Fox, Chicago, *Chairman*
Robert J. Becker, Joliet
Finley W. Brown, Jr., Chicago
Herschel L. Browns, Chicago
Jack Gibbs, Canton
James Habegger, Aurora
Robert R. Hartman, Jacksonville
Lawrence L. Hirsch, Chicago
Eugene P. Johnson, Casey
John P. Johnson, Forest Park (Pres., Student Bus. Session)
Harold Lasky, Chicago
Joseph Moles, Oak Park
Donald Quinlan, Chicago
John J. Ring, Mundelein
Anthony Savino, Chicago (Pres., Resident Phys. Section)
P. John Seward, Rockford

Joseph C. Sherrick, Chicago
Alex Spadoni, Joliet
Alan Spector, Chicago
Fred Z. White, Chillicothe
Cyril C. Wiggishoff, Chicago

STAFF: Division of Administration

Responsibilities and Purposes:

The President-Elect shall serve as the Chairman of the Committee on Planning and Priorities. This Committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President.

HOUSE COMMITTEE ON REDISTRICTING

John J. Ring, Mundelein, *Chairman*
 Julian W. Buser, Belleville
 E. Newton DuPuy, Quincy
 C. Larkin Flanagan, Chicago
 Jere E. Freidheim, Chicago
 Aaron B. Gerber, Park Forest
 Lawrence L. Hirsch, Chicago

Wayne N. Leimbach, Aurora
 Eugene T. Leonard, Rockford
 Warren D. Tuttle, Harrisburg

CONSULTANTS:
 Fredric D. Lake, Evanston
 J. M. Ingalls, Paris

TASK FORCE ON MANDATORY CONTINUING MEDICAL EDUCATION

Joseph C. Sherrick, Chicago, *Chairman*
 George Andrews, Ottawa
 Ex. Dir., Ill. Assoc. of Osteo. Physicians
 Dean Bordeaux, Peoria
 Norman Frank, Clarendon Hills
 Donald F. Pochly, Chicago
 D. Dax Taylor, Springfield

CONSULTANTS:
 C. Clarke Mangun, AMA, Chicago
 David S. Fox, Chicago

STAFF: Division of Education, Manpower, and
 Convention Services

TASK FORCE ON PROFESSIONAL LIABILITY

Fredric D. Lake, Evanston, *Chairman*
 Illinois State Medical Society
 George Andrews, Ottawa
 Ill. Assoc. Osteopathic Physicians
 Thomas Baffes, Park Ridge
 Chgo. Surgical Society
 Edmund C. Bolton, Chicago
 Ill. Chap. Am. Coll. of
 Emergency Phys.
 Phillip D. Boren, Carmi
 ISMS
 Joseph Caminiti, Oak Brook
 Ill. Hosp. Assoc.
 Clinton L. Compere, Chicago
 Ill. Orthopaedic Society
 George G. Curl, Oak Park
 Chgo. Urological Society
 David L. Doud, Normal
 Amer. College of Surgeons
 Charles F. Downing, Decatur
 Ill. Chap., Amer. College of Phys.
 Deane M. Farley, Riverside
 Ill. OB-GYN Society
 David S. Fox, Chicago
 Chicago Medical Society
 Herb Gardner, Oak Brook
 Ill. Hospital Assoc.
 John P. Harrod, Jr., Chicago
 Amer. Coll. OB-GYN, Ill. Sec.
 Welland A. Hause, Decatur
 Ill. Soc. of Pathologists
 Henri Havdala, Chicago
 Ill. Soc. of Anesthesiologists
 J. M. Ingalls, Paris
 ISMS
 Harold Kirk, Oak Park
 Ill. Assoc. of Ophthalmology
 Robert E. Knight, Normal
 Ill. Soc. of Ophth. & Otolaryngology
 Harold Lasky, Chicago
 Chicago Radiological Society
 Alan E. Lasser, Skokie
 Ill. Dermatological Soc., Inc.

Robert Lindley, Chicago
 Chicago Medical Society
 James H. Mason, Evanston
 Ill. Surgical Society
 Guy Matthew, Chicago
 Ill. Radiological Society
 Peter McKinney, Chicago
 Chicago Society of Plastic Surgery
 Tassos Nassos, Chicago
 Ill. State Medical Society
 Robert O'Leary, Oak Brook
 Illinois Hospital Association
 Clyde Phillips, Chicago
 Cook County Phys. Assoc.
 Mark M. Pomaranc, Chicago
 Ill. Chap., Amer. Coll. of Phys.
 Karl Richardson, Chicago
 Chicago Dental Society
 David Rothstein, Chicago
 Ill. Psychiatric Society
 Carlo Scuderi, Chicago
 Ill. Orthopaedic Society
 Ronald Severino, Wheaton
 Ill. Society of Internal Medicine
 Joseph H. Skom, Chicago
 ISMS
 Irwin A. Smith, Northbrook
 Ill. Academy of Family Phys.
 Thomas Starshak, Aurora
 Ill. State Dental Society
 Thomas Szwed, Chicago
 Ill. Assoc. Osteo. Phys. & Surgs.
 Eugene Vickery, Lena
 ISMS
 Walter W. Whisler, Chicago
 Ill. Neurosurgical Society
 Don Wood, Chicago
 Chicago Hospital Council

CONSULTANTS:
 Joel Edelman, Esq.
 John Norris, American Health Systems

Other Appointments and Representatives

REPRESENTATIVES TO STUDENT LOAN FUND BOARD

Donald Stehr, Wheaton, *Chairman*

Albert G. Bledig, Eldorado

Jack Gibbs, Canton

STAFF: Division of Education, Manpower and
Convention Services

Purpose:

ISMS representatives on the Student Loan Fund Board are responsible to the Board of Trustees in matters related to administration of the Student Loan Program operated jointly with the Illinois Agricultural Association.

INA-ISMS JOINT PRACTICE COMMITTEE

James E. Cocur, Carthage

Joseph Lloyd-D'Silva, Wilmette

Robert M. Reardon, Bloomington

Fred Z. White, Chillicothe

STAFF: Division of Education, Manpower and
Convention Services

Responsibilities and Purposes:

The purposes and objectives of the committee shall be to: (1) improve communication between medicine and

nursing to enhance joint planning and action; (2) examine roles and functions in medical and nursing practice with definition of new and altered patterns; (3) propose changes in educational patterns and relationships that would enhance the new role functioning of nurses and physicians; (4) define, identify and examine health care needs; (5) address the traditional problems which affect nurse-physician relationships in order to establish enhanced role functioning, and (6) identify and address the ensuing problems related to basic role reorganization.

ILLINOIS COOPERATIVE HEALTH DATA SYSTEMS

Philip D. Boren, Carmi

Audley F. Connor, Chicago

Joel Edelman, *Consultant*, ISMS

Alexander Goldstein, Harrisburg

Allan L. Goslin, Streator

Donald H. Hanscom, Hinsdale

James A. McDonald, Geneva

Joseph R. O'Donnell, Glen Ellyn

Clifton L. Reeder, Park Ridge

Roger N. White, *Executive Administrator*, ISMS

Ben T. Williams, Urbana

ISMS REPRESENTATIVES TO OTHER GROUPS

SWANBERG FOUNDATION, QUINCY

Robert R. Hartman, Jacksonville

LIAISON TO ILL. SOC. OF THE AMER. ASSOC.
OF MED. ASSTS.

Eli Borkon, Carbondale

ILLINOIS COUNCIL OF HOME HEALTH AGENCIES

Francis Bihss, Belleville

CHICAGO ALLIANCE FOR VD AWARENESS

Edward Piszczek, Chicago

DRUG ABUSE COUNCIL OF ILLINOIS

Joseph Skom, Chicago

PEDIATRIC COORDINATING COUNCIL

Daniel Pachman, Chicago

ILL. INTERAGENCY COUN. ON SMOKING AND DISEASE

Charles L. Swarts, Oak Park

ILLINOIS MEDICAL RECORDS ASSOC.

David T. Petty, Chicago

MD COMMITTEE ON OPTOMETRY

Samuel Schall, Chicago

STATEWIDE COOPERATING ORGANIZATIONS OF THE

COMMISSION ON CHILDREN

Daniel Pachman, Chicago

ILLINOIS CANCER COUNCIL

William M. Lees, Lincolnwood

CITIZENS COMMITTEE FOR AN ILLINOIS PROGRAM TO

CONTROL HIGH BLOOD PRESSURE

David Littman, Glencoe

U.S. PHARMACOPAEA

Joseph Skom, Chicago

The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in the Reference Section. Members who wish to notify Chairman of the Board of their availability can clip and submit the coupon below.

NAME: _____

ADDRESS: _____ CITY: _____ ZIP: _____

TELEPHONE: () _____

COUNTY MEDICAL SOCIETY: _____

MEDICAL SPECIALTY AND TYPE OF PRACTICE _____

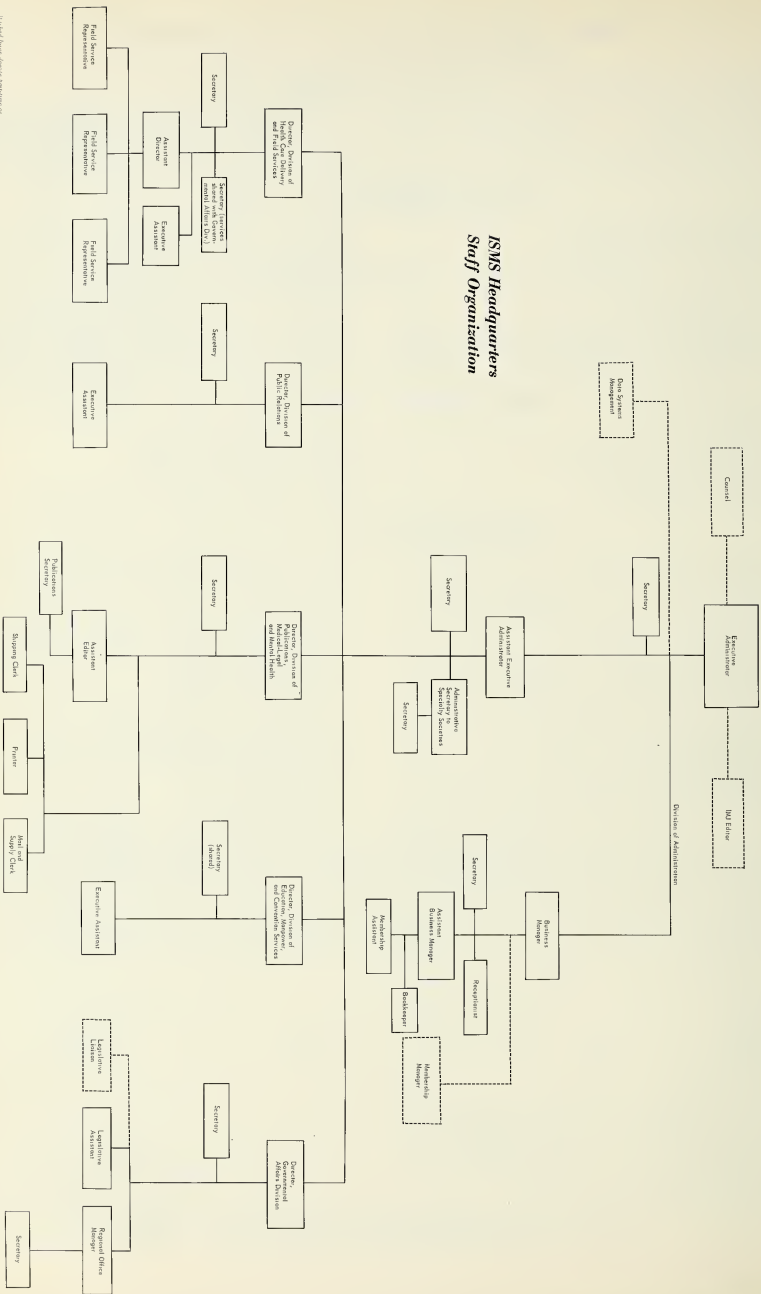
COMMITTEE IN WHICH INTERESTED: _____

EXPERTISE FOR THIS COMMITTEE: _____

SEND TO: Chairman, Board of Trustees, Illinois State Medical Society

55 E. Monroe, Suite 3510, Chicago, IL 60603

ISMS Headquarters Staff Organization



ISMS SERVICES

Pursuit of Obligations

CONSTITUTIONAL PURPOSES OF THE ILLINOIS STATE MEDICAL SOCIETY ARE:

- to promote the science and art of medicine
- to protect the public health
- to evaluate standards of medical education
- to unite the medical profession behind these purposes
- to unite with similar organizations in other states and territories of the United States to form the American Medical Association.

The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

To fulfill these purposes, the Society maintains a headquarters office at 55 East Monroe St., Suite 3510, Chicago, and an office in Springfield at 520 S. Sixth St. Services of the Society, under the general supervision of Roger N. White, Executive Adminis-

trator, are conducted by the following divisions:

Administration; Public Relations and Membership Services; Governmental Affairs; Publications, Medical Legal and Mental Health; Education, Manpower, and Convention Services; and Health Care Delivery and Field Services.

Many and varied are the activities of the Society in pursuit of its obligations. Some of these activities are major programs of statewide (and sometimes national) interest for all citizens; others are of special interest to doctors; still others are sponsored for specific groups or individuals.

Following are general descriptions of the Society's divisions and the programs, services and publications available directly to Society members or sponsored for their benefit.

Specific areas of responsibility and staff assignments will be identified to any member upon request.

DIVISION OF ADMINISTRATION

The Executive Administrator has the responsibility and the authority to provide for the smooth and efficient functioning of the Illinois State Medical Society.

The implementation of established policy, fiscal and budgetary matters, the employment of qualified personnel and the development and maintenance of personnel policies are all part of the Administrator's activities.

He maintains liaison with the Board of Trustees and assists the chairman in carrying out his duties. Close cooperation with the Speaker of the House of Delegates and the officers of the Society provides a smooth and efficient atmosphere in which the Society may function. Cooperation is maintained with the Committee on Constitution and Bylaws to present to the House all suggested changes for official action. The Administrator channels all legal inquiries and works with the

General Legal Counsel to provide guidance to the officers, trustees, committee chairmen and county medical society officers.

The headquarters office has been organized by divisions to provide the membership of the Society with the best professional staff services available.

The Assistant Executive Administrator serves within this Division as a coordinator for programs of the state society. Further coordination between programs of the State Society and the County Medical Societies is achieved through Field Services Representatives.

The accounting and business service functions of the Society are handled by the Business Manager as a part of this Division. The Division also maintains the membership records and provides a computerized central dues billing and collection center for county medical societies. The Society's accounting and membership records are handled in close coordination with the Secretary-Treasurer under policies laid down by the Finance Committee and the Board of Trustees.

DIVISION OF EDUCATION, MANPOWER AND CONVENTION SERVICES

The Division of Education and Manpower was established in response to the growing demands created by the rapid changes in the education and utilization of physicians and other health care personnel. A primary responsibility of the Division is to maintain information on the changes in medical education. The Division works in concert with the AMA in keeping abreast of changes in medical school curricula, and in postgraduate medical education.

In addition, the Division attempts to maintain current information on the training and use of such ancillary

personnel as nurse practitioners and physician's assistants. New and innovative use of personnel are studied and recommendations made to the ISMS Board of Trustees as to their appropriateness and legality. All information maintained by the Division is, of course, available to all ISMS members.

The Division is responsible for matters of medical licensure examinations and issuance, and maintains liaison with the Department of Registration and Education to ensure that any licensure problems may be handled expeditiously.

A second major responsibility of the Division is the

administration of Insurance Programs sponsored by the Illinois State Medical Society. Included in these programs are a Major Medical and Excess Limits Major Medical programs, Group Life, Disability and Hospital Benefits Programs. The Division oversees the day to day operation of the programs, including the enrollment of new physicians. In addition the Division receives regular reports on the programs outlining such information as the

As professional medicine strives to maintain the vigorous condition of the public health, the profession is vitally and intimately concerned with legislative actions of the Illinois General Assembly and the U. S. Congress which affect physicians, other members of the healing arts, and the lay public. To insure that the best health interests of the public and professional interests of the physician are served, the Division monitors all state and national legislation which affect the health of the individual and his community.

The monitoring process is designed to present the thoughtful views of professional medicine in Illinois on specific medically-related pieces of legislation.

The ISMS Governmental Affairs Council acts as the clearing house for legislative proposals recommended by specialized ISMS committees; generated by allied groups; produced by special interests and introduced by representatives and senators. Such legislation is thoroughly analyzed by physician-members of the specialized ISMS committee covering the subject matter of the introduced legislation.

Support or Oppose Legislation

Upon appropriate consideration and recommendation, legislation of medical significance in the Illinois Legisla-

number of physicians enrolled in the program, amount of premium paid, amounts or money disbursed in claims settlements, etc.

The Division is also responsible for coordinating meetings and conventions for all divisions, as well as the services and arrangements incident to the annual and interim sessions.

GOVERNMENTAL AFFAIRS DIVISION

ture is either supported or opposed to protect and promote the interests of the public and the profession. Pertinent subject matter testimony is presented before the House and Senate committees as the bill proceeds through the legislative process.

On-the-scene surveillance of monitored legislation is maintained by ISMS legislative representatives.

Through these essential actions, ISMS plays a meaningful role in shaping legislation for the betterment of the people of Illinois.

Action similar to the above is taken with respect to bills in Congress when they have special significance to Illinois physicians. This activity is conducted in concert with the American Medical Association.

Integrated with and designed to augment the legislative activity is the Public Affairs Program. The ISMS Public Affairs Committee strives to alert the physician to his role in public affairs and to involve him in effective participation in public affairs in his community, state, and nation.

Other Activities

The division also staffs the committees on Public Affairs, Eye Health, Ear, Nose and Throat, and National Legislation.

DIVISION OF HEALTH CARE DELIVERY AND FIELD SERVICES

Health Care Delivery

The Division of Health Care Delivery and Field Services has responsibility for keeping ISMS members abreast of socio-economic issues that have an impact on the delivery of health care.

The Division includes in its activities research on new health care programs being proposed or developed throughout the state. Such pertinent socio-economic information will be disseminated to the membership through articles in the *Illinois Medical Journal*, "Action Report," special educational programs developed by the Division and the Field Service.

The Division staffs the Council on Economics and Peer Review and its Committee on Peer Review Appeals. Principal duties of the Council concern relations with the health insurance industry and governmental health programs. The Peer Review Appeals Committee serves as the appellate body for all disputed cases initially considered by county and district peer review committees.

The Division staffs the Council on Medical Service. The Council initiates and implements programs related to health education, medical facilities and services. It also maintains liaison with other health care organizations involved with vocational rehabilitation, Workmen's Compensation, aging, the poor, rural areas and emergency medical services.

In addition, the Council and its Committee on Maternal Welfare cooperate with the Illinois Department of Public Health in the maintenance, protection and improvement of the health of the people of Illinois. Immunization programs, maternal welfare and hypertension screening programs are examples of the areas of cooperation between ISMS and IDPH.

The Division has responsibility for the Council on Affiliate Societies, in order to enhance communications and liaison with the specialty organizations.

Additional division activities include the stand-by Committee on Governmental Health Program Reimbursement, which deals with Medicare, Medicaid, MEDICARE and CHAMPUS matters involving physician participation; and the Health Planning Committee, which closely follows the activities of the State Planning Agency, Statewide Health Coordinating Council, Illinois Health Facilities Planning Board and local Health Systems Agencies.

Staff of the Division attend meetings of governmental and professional organizations involved in the above described areas and participate in hearings and programs used to develop policy and programs regarding these issues.

Field Services

The primary responsibility of Field Services is to provide liaison, service and education to the Society's membership through Field Service Representatives. Each Field Representative has the responsibility for liaison with component societies, allied professions and government agencies, to insure State Society representation and to provide a means for communication; service to the trustees, officers, executives, general membership and county medical societies; to provide a constant update on ISMS information, programs and resources; and education to the general membership through the distribution of a wide variety of issues affecting the practice of medicine. Specific areas of activity include health planning, President's Tour, Trustee District meetings, the legislative key-man program, and membership Medicaid and Medicare Services.

DIVISION OF PUBLIC RELATIONS AND MEMBERSHIP SERVICES

The Division of Public Relations functions both as an outlet to the news media and as a source of information for the membership.

Staff members prepare speeches, slide presentations, pamphlets and other materials on a wide range of topics to support activities of officers, councils and committees. In addition, the Division arranges press conferences and prepares news releases to publicize ISMS actions and views on major issues. Also, the Division serves as liaison to the news media, responding to almost daily requests for background information or summaries of society activities.

Beyond these traditional public relations duties, the Division conducts a number of special, highly successful projects. Among them are:

President's Tour . . . takes the ISMS President to each Trustee District and provides an opportunity for members to discuss with the president matters affecting medicine and the society. An integral part of the "tour" is

press conferences and media interviews as well as civic club speaking engagements arranged by the division.

Action Report . . . is a periodic newsletter which reports on ISMS activities and major events affecting medicine.

AID (Athletics . . . Injury and Disease) . . . assists coaches and trainers in prevention, recognition and initial treatment of injuries and illnesses. This quarterly sports-medicine newsletter is distributed to approximately 2,000 junior and senior high school coaches and trainers in Illinois.

Radio-TV Speaker's Bureau . . . provides physicians to discuss general medical topics on regularly-scheduled programs. In addition, the bureau provides physician speakers for civic, fraternal, church and community groups.

Public Service Radio Announcements . . . providing general health information are distributed to approximately 150 Illinois radio stations.

DIVISION OF PUBLICATIONS, MEDICAL-LEGAL, AND MENTAL HEALTH

The Division of Publications, Medical-Legal and Mental Health is charged with staff responsibility for activities associated with the Council on Mental Health and Addiction, Medical Legal Council, and the Publications Committee. Under the councils are several committees and subcommittees. In addition, liaison is maintained with many public and voluntary organizations, on a formal basis, in order to keep abreast of current developments and to ensure representation of the Illinois State Medical Society. Staff functions include various activities in professional liability, as well as work on specific problem areas allied to medical-legal concerns.

Publications

Total production of all printed materials and publications, as well as their distribution, is this division's responsibility, except for distribution of items to selected specific groups. Printing and duplicating services are furnished either through an in-plant shop or outside services through competitive bidding.

In addition, mail room services are provided by this division. An addressograph and graphotype are utilized as well as a small wing mailer, folder and stuffer, and plate burning cabinet.

Principal among the publications of the society is the official organ, the *Illinois Medical Journal*. The *Journal* is mailed monthly to all members, as well as other selected individuals, who are urged to read it to keep abreast of the scientific, economic, political, legal and social developments within the state, as such pertain to the practice of medicine.

"Action Report" is an in-house publication totally produced in the ISMS print shop. Special publications, brochures, flyers, pamphlets, letters and cards as required by the several ISMS divisions to carry forth their mission, are produced.

Needs of groups affiliated with or ancillary to ISMS, insofar as reproduction or distribution services are concerned, are also handled through the division office.

Advertising

Commercial advertising is carried within the *Illinois Medical Journal*. The maintenance of the records of advertisers, insertion orders, contracts, and direct communication and liaison with advertising agencies and pharmaceutical houses fall within the purview of the division.

SPECIAL PUBLICATIONS

Action Report

"Action Report" is a periodic newsletter published by the Illinois State Medical Society. It is distributed to members upon request. Purpose of the report is to alert physicians to important events or activities affecting the practice of medicine.

A short deadline ensures that important news is disseminated to the physicians as quickly as possible so that appropriate responses may be made.

On the Legislative Scene

Emanating from the Springfield Regional Office is a weekly newsletter, "On the Legislative Scene," published during the weeks the General Assembly is in session.

This is produced by the Governmental Affairs Division and distributed upon request. It includes up-to-the-minute status reports on pending legislation of vital concern to medicine in Illinois. This well-received periodical has permitted immediate response by ISMS representatives in Springfield to specific bills and has alerted physicians to the need for involvement in public affairs.

SCIENTIFIC SPEAKERS BUREAU

The Illinois State Medical Society, through its Scientific Speakers Bureau, aids county societies in their efforts to keep members abreast of medical advances by conducting postgraduate medical education programs in their own areas. This assistance includes obtaining speakers, preparing and mailing notices of meetings, and paying an honorarium and travel expenses. ISMS can also provide publicity services upon request.

It also pays a \$50 honorarium and expenses for individual speakers obtained by county medical societies for their regular meetings.

The Bureau operates under a grant from Merck, Sharpe & Dohme, which provides funds to the ISMS Educational and Scientific Foundation for the specific purpose of obtaining speakers for county medical society meetings.

The following procedures govern use of the Bureau:

- 1) County societies select speakers from a roster containing the names of more than 400 speakers and over 1,000 topics.

- 2) Publicity to media in the area of the meeting will be handled by ISMS upon request of the county society.

- 3) Postcard notices will be mailed to physicians in the county if requested. ISMS will prepare and mail notices if the information is received no less than three weeks prior to the meeting.

- 4) The county medical society program chairman and the speaker are both expected to submit to ISMS a report on the meeting and the arrangements.

PHYSICIAN RECRUITMENT & STUDENT LOAN FUND PROGRAMS

The Illinois State Medical Society not only offers help to students who wish to become physicians, but also is able to assist the careers of those already licensed to practice medicine.

The society provides this aid through two special activi-

ties. First is its own Physician Recruitment Program & Doctor's Job Fair. Second is the Illinois Medical Student Loan Fund Program that the society sponsors in conjunction with the Illinois Agricultural Association.

PHYSICIAN RECRUITMENT PROGRAM

The Physician Recruitment Program is designed to help physicians find a desirable area in which to establish practice or to relocate. The program's purpose is twofold, since it is interested also in helping those communities which demonstrate need of a physician.

More than 600 medical doctors have been placed through this program since its inception shortly after World War II.

The Physician Recruitment Program maintains an up-to-date listing of some 125 "open" areas needing physicians.

This service accepts requests from both physicians and communities for placement. In addition, physicians are referred to the service by a number of organizations, among them the American Medical Association and the Illinois Agricultural Association. Frequently, responsible

citizens or overburdened physicians in a community will contact the service.

Another important function of the Physician Recruitment Program is to assist small communities in developing programs to attract physicians such as the Doctor's Job Fair.

The Physician Recruitment Program sends a questionnaire to the applicant physician to obtain information on his educational background, his interests and preferences of type of practice. Upon return of the questionnaire, the physician is sent a complete list of openings. Each opening is detailed on its facilities for home life, office space, proximity to hospital facilities and other specifics.

The Physician Recruitment Program offers its assistance to all qualified physicians who request it. An applicant need not be a member of the state medical society.

ILLINOIS MEDICAL STUDENT LOAN FUND PROGRAM

The Illinois Medical Student Loan Fund Program is designed to help those who have what it takes to become a physician, but lack sufficient financial resources or a recommendation for medical school.

Loans to students in need are provided by a joint contribution from the Illinois State Medical Society and the Illinois Agricultural Association. The program offers loans up to \$750 per semester for four years. The total amount of loan funds available varies from year to year, depending on repayments into the revolving fund. The amount of each individual loan is determined by the student's current financial need. Loan installments are made twice a year. A low interest rate is charged semi-annually from the time the loan is received. The borrower also must insure himself for the entire amount of the loan and pay premiums on the policy. Repayment begins January 1 of the fourth year following medical school graduation.

The program also offers assistance to those who may not have financial difficulties, but are denied matriculation

into medical school because their college grades or Medical College Admission Test (MCAT) scores are marginal. The board representing the sponsoring organizations of the program can recommend candidates annually to the University of Illinois College of Medicine. After careful screening to determine whether the applicant has the potential to make a good medical student, the board can recommend him for admittance on the basis of its investigation.

In return for this assistance from the Medical Student Loan Fund Program, the applicant must agree to practice medicine in an Illinois town serving a rural population. Minimum practice time is:

- (1) Freshman student receiving recommendation—five years of practice.

- (2) Freshman student receiving financial assistance for four years—four years of practice.

- (3) Upper classman already in medical school—one year of practice for each year that financial aid is taken (one year minimum).

The applicant may select a practice location of his own choice, provided it is in a community that has a demonstrated physician shortage. The choice is subject to approval by the program's board. The purpose of this agreement is to provide family doctors for the rural communities of Illinois.

To be considered for assistance from the Medical Student Loan Fund Program, an applicant must be recommended by the presidents of his home county medical society and farm bureau. Rules of eligibility require that an applicant be a premedical student of at least three years college standing; that he take a medical college admissions test; and that his college grade transcript be submitted

with the completed application form. Students applying to this program for a recommendation must complete an official application for admission to the University of Illinois by November 1. Illinois residency is required.

The board of the Medical Student Loan Fund Program conducts an annual interview meeting for those students who wish to enter medical school the following September. Students qualifying for the interview are notified and invited in mid-November. Those approved for assistance are accepted on a comparative and competitive basis. Information and applications may be obtained from Roy E. Will, Manager, Medical Student Loan Fund Board, 1701 Towanda Ave., P.O. Box 2901, Bloomington, IL 61701.

IMPARTIAL MEDICAL TESTIMONY

The Impartial Medical Testimony program, in which the Illinois State Medical Society participates, is designed to elicit objective medical truth and facilitate the equitable disposition of cases in the courts of Illinois.

As a technique of judicial administration, impartial medical testimony examiners are ordered by the court when there is evidence of a wide divergence of medical opinion in the case which is subject to litigation. The introduction of the IMT examiner and subsequent examination provides the court with objective, impartial medical data for use in pre-trial conferences and in jury

trials.

The Illinois State Medical Society played a significant role in the creation and development of the IMT program.

The panel of impartial medical examiners is comprised of physicians who are grouped into medical specialties. Composition of the panel is reviewed periodically to maintain the highest standards for the courts of Illinois.

In 1976 the functions of IMT were expanded to provide service to the Supreme Court Attorney Registration and Discipline Commission.

SPONSORED COMMERCIAL INSURANCE PROGRAMS

Hospital Income Plan

The Hospital Benefit Plan, approved by the Board of Trustees March 14, 1971, is available exclusively as a benefit to ISMS members. The society derives no income from sponsorship.

The Plan pays \$25 in cash (Plan A) or \$50 in cash (Plan B) for each day the participant is confined to a hospital because of accident or illness for as long as one full year, up to \$9,125 (Plan A) or \$18,250 (Plan B) for each accident or sickness.

All active members of the society, their employees and their families are eligible for participation during enrollment periods conducted by the Administrator, Robinson Administrative Services, Inc., 209 S. LaSalle St., Chicago 60604.

The daily benefits are automatically doubled for all participants under age 65 for hospital confinement due to cancer or hospital confinement in an intensive care unit.

The plan pays regardless of any other insurance policies members have, and in addition to Medicare and Social Security benefits. Benefits are paid directly to the participant and not to a doctor or hospital, unless assigned. Benefits are not taxable and therefore need not be included in one's tax return.

The coverage is limited to sickness which commences or accidents which occur while the insurance is in force. However, conditions pre-existing the effective date of insurance will be covered if the participant has not received treatment or medical advice during any period of 12 consecutive months ending after the effective date of insurance. After two years from the effective date of insurance, coverage is guaranteed regardless of any pre-existing conditions.

The plan includes these exclusions: war or act of war, service in the armed forces of any country or international authority at war, pregnancy (including childbirth or resulting complications), or intentionally self inflicted injuries, suicide or attempted suicide, whether sane or insane.

In summary, in 1971 the Hospital Benefit Plan was made available to the membership and was received very well. During enrollment periods all members regardless of age could participate. Enrollment periods are anticipated every 12 to 18 months.

Group Disability Program

The Illinois State Medical Society's officially approved Group Disability Program is available to all eligible members of ISMS up to age 60 who are regularly attending all of the usual duties of their occupation and is renewable to age 70. Three different types of coverage are available under the program, with an over-70 conversion privilege.

New members under age 40 joining ISMS may enroll without evidence of insurability for up to \$400.00 per month. Benefits under Plan I, (lifetime accident, 1 year sickness). The plan offers up to \$1732.00 per month. Benefits to members under 50 and \$1300.00 per month Benefits to members under age 55.

Benefits of the program are payable regardless of any other insurance and no restrictive riders may be attached after issuance. The master contract contains a special renewal condition whereby the individual coverage cannot be terminated.

The program is explained in detail in a brochure which is available by writing to the administrator, Parker, Aleshire & Co., 9933 Lawler Ave., Skokie 60076.

Group Major Medical Expense Plan

A \$25,000 Group Major Medical Expense Plan designed for the Illinois State Medical Society has a 20% co-insurance feature and a \$500 or \$1,000 deductible, whichever the physician selects. For hospital room and board, the Plan will pay up to \$100 a day and in addition up to \$150 a day in an intensive care unit. It will pay \$20 a day in a convalescent home following release from a hospital up to 90 days. The Plan also provides maximum coverage for the insured in the event of mental illness and up to \$2,000 for dependents. It will also cover a congenital abnormality from the first day of birth after the effective date of the contract up to \$2,000.

New members joining ISMS will be allowed to enroll without evidence of insurability or health statement under age 40 within six months after notification of the Plan's availability.

The Group Major Medical Expense Plan is outstanding and will provide members with protection against catastrophic illness.

Further information may be obtained from the administrator, Parker, Aleshire & Co., 9933 Lawler Ave., Skokie, Ill. 60076.

Business Overhead Expense Group Plan

Today, more than ever, maintaining a medical

office is costly when one considers the increasing cost of rent, employee's salaries, accountant services, utilities, etc. The sole purpose of the Business Overhead Expense Group Plan is to step in and take care of overhead expenses during a period when the physician is totally disabled as a result of an accident or illness. In the event of a serious accident or illness, the physician can keep his office open and retain his personnel with the expenses being taken care of by the Business Overhead Expense Group Plan. This Program is not to be confused with the Group Disability Plan which provides an earned income for physician to meet his personal obligations for the maintenance of his home and family.

Monthly benefits are available up to \$3,500.00 with attractive premiums. Benefits commence on the first day provided total disability lasts one (1) month or longer. It will continue while totally disabled for as long as 24 months for any one accident or period of sickness. The premiums for this particular type of coverage constitute business expenses and are deductible under Internal Revenue Service Ruling (55-264, I.R.B. 1955-19, p. 8).

Further information may be obtained from the administrator, Parker, Aleshire & Co., 9933 Lawler Ave., Skokie, Ill. 60076.

Personal Life Insurance Program

A guaranteed renewable term life insurance program, recommended by the Insurance Committee and approved by the Board of Trustees in 1972, is available to ISMS members in amounts ranging from \$10,000 to \$200,000. Features of the program include guaranteed future purchase options, guaranteed conversion privilege up to age 70, optional

family insurance benefits, double indemnity and disability waiver premium.

Dividends are applied against premiums and reduce member's cost.

For applications and further details, contact the administrator: A. W. Ormiston & Co., 175 W. Jackson Blvd., Chicago 60604; phone 312-922-3952.

Ancillary Organizations

Illinois State Medical Society Auxiliary

Goals for Golden Year

A little gadget called a "key" is a mighty object—a turn with one that is mechanically correct, and, presto, the door is open. Because we believe that medical auxiliary has a potential that has never been fully tapped, we have chosen to use the key as a symbol to unlock the tremendous amount of accomplishment that could pour from one turn of the magic bolt.

Membership in medical auxiliary is a responsibility and a privilege. No one but doctors' spouses can belong. The "tea-party" and "country-club" image can be erased by reaching out and taking an active and visible role in promoting health education and health-related programs. We must be a viable group, proud of our ability as auxiliary members to make a difference to the future of quality health care and the betterment of our communities.

This Golden Anniversary Year we hope to unlock deep and rich potential in our programs—membership, with special emphasis on members-at-large and junior memberships (spouses of medical students and residents); legislation, so vital during these critical times in American medicine; AMAERF, a very tangible proof of our interest in medical education; and particularly, health education of the young, the treasures of our future.

Using the theme "Teach the Children," we will endeavor to launch, on a state-wide basis, projects and ideas that affect the young. We will be working with the Illinois Heart Association to encourage "CPR" training for high-schoolers, as well as adults. Immunization education will be one of our major goals, together with safety (particularly bicycle safety, which is often taken for granted).

Family Health will be stressed—with a special slant on finding “outlets” for teens and routes to handle various pressures from outside the home. Television influence will be brought into focus as a major factor in shaping attitudes of our young. The importance of good nutrition and physical fitness will not be forgotten as important universal health issues.

The auxiliary message will be conveyed this year through county visits, district meetings and a fall conference in Joliet on October 18. All members are invited to participate in a day-long conglomeration of programs specially planned to put our year's plan into action. The conference will also present a perfect time for reports from the AMAA's Leadership Confluence which ten county presidents-elect, state president-elect and state president will attend in Chicago October 9 through 12. Each county president is encouraged to get a group together and be a part of this important auxiliary “rap” session.

Our quarterly publication PULSE has set its sights on county news—each county is asked to forward news covering at least three events during the year. Co-operate, communicate, co-ordinate—help us to unlock Auxiliary potential!

“Appreciate the past . . . Anticipate the Future”
When you care about tomorrow, you plan to meet its needs.

Mrs. Edward (Betty) Szewczyk
President

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American Association of Medical Assistants Illinois Society

The American Association of Medical Assistants is a national, non-profit organization dedicated to the professional advancement of medical assistants. This tri-level structure—similar to AMA—encompasses local, state and national affiliation.

Membership in the Illinois Society, AAMA, is open to medical assistants, office nurses, technicians, secretaries, bookkeepers and clerks performing administrative and/or clinical duties under the direct supervision of a physician. College students attending Medical Assistant Programs are encouraged to belong. Physician advisors at all three levels assist with educational endeavors.

The State Society's numerous professional, educational programs in various parts of the state offer continuing education units (CEU) to its participants. Some of the major programs are:

Traveling Course Seminars, Annual Symposium, Personal Development Day and the All Day Workshop held in conjunction with Chicago Medical Society's Midwest Clinical Conference. The Annual 3 day Meeting in April includes excellent lectures, study programs and the culmination of association business during the House of Delegates Session.

The American Association of Medical Assistants encourages advancement of medical assistants by offering a certification examination designed to evaluate professional competency. Local chapters, in addition to their regularly scheduled monthly educational programs, conduct preparatory classes in terminology, physiology, anatomy, human relations, patient contact, medical law and ethics, communications, bookkeeping, insurance, administrative procedures, laboratory orientation and collection methods. The certification examination is administered twice a year.

The medical assistant may become a Certified Medical Assistant (CMA) by successfully passing the special board examination and meeting qualifying criteria of the American Association of Medical Assistants. Specialty examinations are given in Administrative, Clinical and Pediatric divisions. For further information about this program contact the American Association of Medical Assistants, One

East Wacker Drive, Chicago, Illinois 60601.

Members interested in independent continuing education through a "home study" program may purchase and utilize audio cassettes and workbooks. The president of the Illinois Society communicates, via the "Executive Memo" (a monthly publication), with nearly 1,000 members giving pertinent information of current activities.

A quarterly publication "The Illini Cardinal" concentrates on educational topics and is available to all members without additional cost. "The Professional Medical Assistant," the official bi-monthly journal of the association, is largely devoted to original articles written for medical assistants by their peers or other professionals in related fields. It is an automatic benefit of membership, although subscriptions are available for non-members. There are many other benefits available (i.e. group insurance). During the Annual Meeting of AAMA each fall, a variety of experts in medical and related fields address participants during educational programs and workshops.

Monthly educational meetings are scheduled in the following chapters: Cook County-Chicago (downtown), Southwest Suburban (Oak Lawn), Northwest (Arlington Heights), Northshore (Skokie), West Cook (River Grove), Cook County South (Dolton), Aux Plaines (Oak Park), DuPage (Wheaton), Coles-Cumberland (Charleston), DeKalb (Sycamore), Jefferson-Hamilton (Mt. Vernon), Hancock (Carthage), Kane (Elgin), Kankakee, LaSalle, Macon (Decatur), McLean (Bloomington), McDonough (Macomb), McHenry, Morgan-Scott (Jacksonville), Randolph (Chester), Rock Island, Sangamon (Springfield), St. Clair (Belleville), Spoon River Valley (Canton), Vermilion (Danville), Will-Grundy (Joliet), Shawnee (Harrisburg). Physicians in these areas are asked to encourage their medical assistants to join the association and actively participate in the selection of educational programs that will enable the members to become better medical assistants.

For membership information please contact Mrs. Vivian Kraft, CMA-AC, President, Illinois Society, AAMA, 801 Broadmoor Drive, Bloomington, Illinois 61701.

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The Educational & Scientific Foundation

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

1) The initiation of scientific and medical research activities.

2) The collection, evaluation and dissemination of the results of research activities to the public.

3) The implementation and management of projects related to medicine for individuals, or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which

has an interlocking Board with the Illinois State Medical Society. It is staffed through ISMS headquarters.

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STAFF: Division of Education, Manpower and Convention Services.

Illinois Council on Continuing Medical Education

This Council was created by the Illinois State Medical Society, in co-operation with the state's eight medical schools, to fulfill six purposes: (a) make readily available to all Illinois physicians CME programs that will enhance patient care; (b) catalog and co-ordinate existing programs to eliminate wasteful duplication; (c) encourage development of new CME methods, techniques, and systems; (d) help identify the learning needs of Illinois physicians; (e) seek out potential CME providers and serve as liaison between producers and consumers; and (f) encourage Illinois physicians to participate in formal CME programs.

ICCME was proposed by Dr. Edward W. Cannady in his 1969 inaugural address as President of ISMS. Following careful study, the 1970 House of Delegates approved the plan in principle. The next President, Dr. J. Ernest Breed, vigorously pursued the idea; after the 1971 House of Delegates voted initial funding, he also served as Chairman of the Organizing Committee. The Illinois Association of Osteopathic Physicians & Surgeons also offers financial support for ICCME.

ICCME was officially chartered by the state as a non-profit educational organization in May, 1972, and began operations with the appointment of its first Executive Director in September, 1972.

ICCME is unique in three respects: (1) it is the only such organization supported by a state medical society and staffed by a full-time professional educator; (2) it unites the educational resources of the Illinois State Medical Society and the state's medical schools; and (3) independent in action, it serves all interests concerned with CME and thus provides a crucial channel of communication to co-ordinate the efficient use of all available resources.

Current Major Activities:

1. Sponsor an annual Congress on Continuing Medical Education, to involve all elements of the Illinois health-care system in the Council's work. The fifth

Congress meets April 21-22, 1978.

2. On behalf of ISMS, perform staff work for accreditation of intra-state CME including advice on preparing to apply for Accreditation.
3. Advise hospitals and other organizations on effective CME—both informally and through the "Illinois Hospital CME Consultation Service."
4. Organize workshops on techniques of CME—including an unusual "Workshop on CME Leadership" for leaders of hospital medical staffs and medical societies.
5. Develop and publish CME planning aids that offer practical advice and important background on effective organization of CME. Included are *Your Personal Learning Plan*, a unique handbook offering advice on how to plan your learning most effectively; and *How to Start a CME Program in Your Hospital or Medical Society* for CME planners. For all items now available, request "The Illinois Handbooks on CME Planning—Catalog/Order Form." All publications are free to Illinois physicians—M.D. or D.O.—upon request; just write the title on your prescription form and mail to ICCME, 55 E. Monroe, Chicago, IL 60603.
6. Publish an *Illinois CME Case Compendium* for hospital CME case-discussion groups.
7. Publish a monthly calendar of Illinois CME activities for *IMJ*.

Organization & Governance

Members of the ISMS Executive Committee serve as legal members of the ICCME Corporation, set basic policy, and elect the Board of Directors.

The affairs, property, and business of the Council are managed by a Board of Directors comprised of: eight practicing physicians selected by the ISMS Board of Trustees; eight academic physicians, one selected by each dean of an Illinois medical or osteopathic school; plus the chairman of the ISMS Committee on CME Accreditation.

Board of Directors

William Lees, Lincolnwood, *President*
Donald F. Pochly, Chicago, *Vice-President*
Ward E. Perrin, Chicago, *Secretary*
George Shropshire, Chicago, *Treasurer*
Anthony L. Barbato, Maywood
Sheldon Berger, Highland Park
Dean Bordeaux, Peoria
J. Ernest Breed, Chicago
Joseph Daddino, Chicago

James E. Dyson, Ph.D., Chicago
Harold A. Paul, Chicago
Chase P. Kimball, Chicago
Boyd McCracken, Greenville
Mather Pfeifferberger, Alton
Lewis W. Tanner, Danville
D. Dax Taylor, Springfield
Thomas Zimmerman, Chicago
EXECUTIVE DIRECTOR: Leonard S. Stein, Ph.D.

Illinois Foundation for Medical Care

The Illinois Foundation for Medical Care (IFMC) is a not-for-profit corporation established in 1971 by action of the House of Delegates. Under revised bylaws adopted June, 1977, IFMC is operated under direction of a 6-member Board of Directors elected annually by the ISMS Board of Trustees. The IFMC currently contracts with the Regional Health Resources Center, Urbana, Illinois for administrative services.

Prior to reorganization, IFMC maintained formal affiliation agreements with 10 local foundations for medical care throughout the state of Illinois. Since the reorganiza-

tion, IFMC maintains informal relationships with these foundations, supplying data processing and other services to them.

Under contract with the state of Illinois the IFMC has operated an in-patient hospital monitoring program known as the Hospital Admissions and Surveillance Program (HASP) since its inception in February, 1972. HASP is currently administered by sub-contracts with 9 of the 10 foregoing local foundations for medical care. HASP is currently in the process of being preempted as PSROs become operational in the local areas.

IFMC Board of Directors

Joseph Sherrick, M.D., Chicago, *President*
Robert P. Johnson, M.D., Springfield, *Vice-President*
James Laidlaw, M.D., Champaign, *Secretary-Treasurer*

Audley F. Connor, M.D., Chicago
Miller Henderson, M.D., Rockford
Lawrence L. Hirsch, M.D., Chicago

Illinois Medical Political Action Committee (IMPAC)

The Illinois Medical Political Action Committee (IMPAC) is a voluntary, non-profit, unincorporated, permanent membership organization founded in 1960. IMPAC serves as the unified political action arm of Illinois physicians and their wives. It cooperates with others in the healing arts professions. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his wife can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the

Illinois General Assembly and in the U. S. Congress. It cooperates in membership solicitation activities with the American Medical Political Action Committee (AMPAC).

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U. S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, Suite 3510, 55 E. Monroe, Chicago 60603.

Illinois State Medical Insurance Services, Inc.

Illinois State Medical Insurance Services is an Illinois corporation, formed in March, 1976, all of whose capital stock is owned by the Illinois State Medical Society. Its sole business is to act as Attorney-in-Fact for the Illinois State Medical Inter-Insurance Exchange.

Insurance Services provides all the management and underwriting services required for the operation of the insurance business of The Exchange. It does so under Power-of-Attorney granted it by The Exchange in a management agreement with an initial term of five years, and by each member of The Exchange through his application for membership. Under the Management Agreement the Board of Governors of The Exchange prescribes policy to be followed in the conduct of the business; within the guidelines established by these policy statements, Insurance Services manages the business of The Exchange, accepting or rejecting applications, determining the form of insurance policies, handling and disposing of claims, and performing all related functions. Insurance Services is compensated by The Exchange on the basis of expense reimbursement; it is not anticipated that Insurance Services will produce any operating profit.

The organization of Insurance Services comprises three

principal functional divisions: Risk Management and Underwriting, Claims, and Policyholder Services. Advisory and consultative services are provided by member physicians through a review system organized and directed by the Medical Director of Insurance Services. Financial and accounting services are provided by staff of the Illinois State Medical Society, whose Business Manager serves as Controller of Insurance Services. The offices of Illinois State Medical Insurance Services, Inc., are at 55 East Monroe Street, Chicago, Illinois 60603.

Board of Directors

Joseph L. Bordenave
Phillip D. Boren
Alfred Clementi
Robert T. Fox
J. M. Ingalls
Roger N. White

Officers

Joseph L. Bordenave, *Chairman*
Paul E. Singer, *President*
Henry Nussbaum, *Vice President*
Roger N. White, *Secretary-Treasurer*
Phillip D. Boren, *Medical Director*

Student Business Session

John Johnson, Forest Park (Loyola) *Chairman*
Jason Chao, Chicago (Northwestern) *Vice Chairman*
Jerry Cohen, Chicago (Northwestern) *Secretary*
David Hopp, Chicago (University of Chicago) *Delegate*
Tony Smith, Rockford (Rockford) *Alternate Delegate*

The purposes of the Student Business Session shall be to encourage and support the active participation of medi-

cal students in the ISMS and to provide a representation of student opinions and ideals in organized medicine. In addition, the Student Business Session shall support the purposes of ISMS as stated in its constitution. The Student Business Session is composed of all student members of ISMS.

Resident Physicians Section

Anthony Savino, Chicago, *Chairman*
Michael Sadove, Chicago, *Vice Chairman and Treasurer*
Ira Isaacson, Chicago, *Secretary and Editor*
Paul M. Stromborg, Sycamore, *Delegate*

The purposes of the Resident Physicians Section shall be to encourage and support the active participation of physicians in training in the Illinois State Medical Society

and to provide representation of intern-resident opinions and ideas in organized medicine. In addition, the Resident Physician Section shall support the purposes of the ISMS, as stated in its constitution. All in-training members of the ISMS shall be members of the Resident Physicians Section, having the right to vote and hold office.

MEDICAL AND ALLIED HEALTH EDUCATION

MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

Chicago Medical School, University of Health Sciences
2020 W. Ogden Ave., Chicago, 60612

Northwestern University Medical School
303 E. Chicago Ave., Chicago, 60611

University of Chicago-Pritzker School of Medicine
950 E. 59th Street, Chicago 60637

University of Illinois College of Medicine*
1853 W. Polk Street, Chicago, 60612

Loyola University, Stritch School of Medicine
2160 S. First Ave., Maywood, 60153

Rush Medical College
1725 W. Harrison St., Chicago 60612

Southern Illinois University School of Medicine
801 N. Rutledge, P.O. 3926, Springfield, 62708

*Note: This is the parent college for Abraham Lincoln School of Medicine, Peoria School of Medicine, Rockford School of Medicine.

ALLIED HEALTH EDUCATIONAL PROGRAMS accredited by the American Medical Association Committee on Allied Health Education and Accreditation

LABORATORY ASSISTANT

DANVILLE—St. Elizabeth Hospital

ELGIN—Sherman Hospital

OLNEY—Richland Memorial Hospital

QUINCY—Blessing Hospital

RIVER GROVE—Triton College

CYTOTECHNOLOGIST

CHICAGO—Michael Reese Hospital & Medical Center
University of Chicago—Lying-in-Hospital

HISTOLOGIC TECHNICIAN

CHICAGO—St. Joseph Hospital
University of Chicago Hospital & Clinics
Mercy Hospital & Medical Center
Mount Sinai Hospital & Medical Center
Holy Cross Hospital

MEDICAL ASSISTANTS

BELLEVILLE—Belleville Area College
CARTHAGE—Robert Morris School
PALATINE—William Rainey Harper College
RIVER GROVE—Triton College

MEDICAL LABORATORY TECHNICIAN

BELLEVILLE—Belleville Area College
EAST PEORIA—Illinois Central College
GODFREY—Lewis & Clark Community College
PALOS HILLS—Moraine Valley Community College

MEDICAL RECORD ADMINISTRATORS

CHICAGO—University of Illinois College of Medicine

NORMAL—Illinois State University

MEDICAL RECORD TECHNICIAN

BELLEVILLE—Belleville Area College
CHICAGO—Central YMCA Community College
EAST PEORIA—Illinois Central College
GRAYS LAKE—College of Lake County
MORTON GROVE—Oakton Community College
PALOS HILLS—Moraine Valley Community College

MEDICAL TECHNOLOGIST

BELLEVILLE—St. Elizabeth Hospital
BLUE ISLAND—St. Francis Hospital
CHAMPAIGN—Burnham City Hospital
CHICAGO—Augustana Hospital & Health Care Center
Grant Hospital of Chicago
Holy Cross Hospital
Illinois Masonic Medical Center
Louis A. Weiss Memorial Hospital
Mercy Hospital & Medical Center
Michael Reese Hospital & Medical Center
Northwestern University Medical School
Rush-Presbyterian-St. Luke's Medical Center
St. Anne's Hospital
St. Anthony Hospital
St. Joseph Hospital
St. Mary of Nazareth Hospital Center

University of Illinois College of Medicine
V. A. Lakeside Hospital
DANVILLE—Lake View Memorial Hospital
DECATUR—Decatur Macon County Hospital
St. Mary's Hospital
EVANSTON—Evanston Hospital
FREEPORT—Freeport Memorial Hospital
GENEVA—Community Hospital
GREAT LAKES—U.S. Naval Regional Medical Center
HINES—V.A. Hospital
HINSDALE—Hinsdale Sanitarium & Hospital
JOLIET—Silver Cross Hospital
St. Joseph Hospital
MAYWOOD—Foster G. McGaw Hosp./Loyola University
NORTH CHICAGO—University of Health Sciences/
Chicago Medical School
OAK LAWN—Christ Community Hospital
OAK PARK—West Suburban Hospital Association
PARK RIDGE—Lutheran General Hospital
PEORIA—Methodist Medical Center of Central Illinois
St. Francis Hospital
QUINCY—St. Mary's Hospital
ROCKFORD—Rockford Memorial Hospital
St. Anthony Hospital
Swedish-American Hospital
SPRINGFIELD—St. John's Hospital
Sangamon State University
URBANA—Carle Foundation Hospital
WAUKEGAN—St. Therese Hospital
WINFIELD—Central DuPage Hospital

NUCLEAR MEDICINE TECHNOLOGY

CHICAGO—Northwestern Memorial Hospital
St. Mary of Nazareth Hospital Center
EVANSTON—Evanston Hospital
HINES—V. A. Hospital
PARK RIDGE—Lutheran General Hospital
RIVER GROVE—Triton College

OPERATING ROOM TECHNICIAN

MOLINE—Moline Public Hospital
PALOS HILLS—Moraine Valley Community College
BELLEVILLE—Belleville Area College

OCCUPATIONAL THERAPIST

CHICAGO—University of Illinois College of Medicine

PHYSICAL THERAPIST

CHICAGO—Northwestern University Medical School
University of Health Science/
Chicago Medical School
University of Illinois College of Medicine

RADIOLOGIC TECHNOLOGIST

ARLINGTON HTS.—Northwest Community Hospital
CENTRALIA—St. Mary's Hospital
CHAMPAIGN—Parkland College
CHICAGO—Central YMCA Community College
Cook County Hospital
DePaul University
Henrotin Hospital
Illinois Masonic Medical Center
Louis A. Weiss Memorial Hospital
Malcolm X Community College
Michael Reese Hospital & Medical Center
Provident Hospital & Training School
Ravenswood Hospital Medical Center
St. Anne's Hospital
St. Joseph Hospital

St. Mary of Nazareth Hospital Center
South Chicago Community Hospital
University of Illinois Hospital
Woodlawn Hospital
Wright Junior College
DANVILLE—Lake View Medical Center
DECATUR—Decatur Macon County Hospital
DIXON—Sauk Valley College
EAST PEORIA—Illinois Central College
ELGIN—St. Joseph Hospital
EVANSTON—St. Francis Hospital
GALESBURG—Carl Sandburg College
GLEN ELLYN—College of DuPage
GRAYSLAKE—College of Lake County
HINSDALE—Hinsdale Sanitarium & Hospital
KANKAKEE—Kankakee Community College
KEWANEE—Kewanee Public Hospital
MACOMB—McDonough District Hospital
MALTA—Kishwaukee College
MOLINE—Lutheran Hospital; Moline Public Hospital
MORTON GROVE—Oakton Community College
NORMAL—Bloomington-Normal School of
Radiologic Technology

OAK PARK—West Suburban Hospital Assn.
OLNEY—Richland Memorial Hospital
PALOS HILLS—Moraine Valley Community College
PEORIA—St. Francis Hospital
QUINCY—Blessing Hospital
St. Mary's Hospital
RIVER GROVE—Triton College
ROCKFORD—Rockford Memorial Hospital
Swedish American Hospital
ROCK ISLAND—Rock Island Franciscan Hospital
SOUTH HOLLAND—Thornton Community College
SPRINGFIELD—Lincoln Land Community College
Memorial Medical Center

RESPIRATORY THERAPIST

CHAMPAIGN—Parkland College
CHICAGO—Cook County Hospital
Central YMCA Community College
Malcolm X College
Northwestern University affiliated hospitals
University of Chicago Hospitals & Clinics
MOLINE—Lutheran Hospital
PALOS HILLS—Moraine Valley Community College
RIVER GROVE—Triton College
ROCKFORD—St. Anthony Hospital
SPRINGFIELD—Memorial Medical Center

RESPIRATORY THERAPY TECHNICIAN

CHAMPAIGN—Parkland College
CHICAGO—Northwestern Memorial Hospital
MOLINE—Lutheran Hospital
QUINCY—St. Mary's Hospital
ROCKFORD—Swedish American Hospital
SPRINGFIELD—St. John's Hospital
WAUKEGAN—Victory Memorial Hospital

RADIATION THERAPY TECHNOLOGIST

CHICAGO—Rush-Presbyterian-St. Luke's Medical Center
EVANSTON—Evanston Hospital
HINES—V. A. Hospital
MOLINE—Lutheran Hospital
ROCKFORD—Swedish American Hospital

SPECIALIST IN BLOOD BANK TECHNOLOGY

CHICAGO—University of Illinois College of Medicine
SPRINGFIELD—St. John's Hospital
PARK RIDGE—Lutheran General Hospital

ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

For representation in the General Assembly, there are 59 Legislative Districts. Each district elects one senator and three representatives. Thus, the Senate has 59 members and the House 177. Under the new constitution, senators are elected for 4 year terms, representatives are elected for 2 year terms.

The General Assembly shall convene each year on the second Wednesday of January. The General Assembly shall be a continuous body during the term for which members of the House of Repre-

sentatives are elected. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States Constitution, and act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the President of the Senate. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. These committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

EXECUTIVE BRANCH

The Constitution provides that the Executive Department shall consist of the Governor, Lieutenant Governor, Secretary of State, Comptroller, Treasurer, and Attorney General. These elected officers of the Executive Branch shall hold office for

four years, beginning on the second Monday of January after their election and, except in the case of the Lieutenant Governor, until their successors are qualified. They shall be elected at the general election in 1976 and 1978 and every four years thereafter.

STATE OFFICERS

1977

Governor, JAMES R. THOMPSON, Rep., Chicago

Lieutenant Governor, DAVE O'NEIL, Rep.,
Belleville

Secretary of State, ALAN J. DIXON, Dem., Belleville

Comptroller, MICHAEL J. BAKALIS, Dem.,
Downers Grove

Treasurer, DONALD R. SMITH, Rep., Springfield
Attorney General, WILLIAM J. SCOTT, Rep.,
Evanston

Clerk of the Supreme Court, CLELL L. WOODS,
Springfield

LEGISLATIVE BRANCH

Legislative Procedure

Each member of the General Assembly has the power to introduce bills or resolutions. When a bill is introduced it is read at large a first time, ordered printed, and referred to the proper committee for consideration, except that in case of an emergency, a bill may be advanced without reference to committee. If the committee recommends the bill favorably, it is sent to second reading when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading after which it is acted upon by the entire membership of the house that is considering it.

Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (89 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference committees may be appointed to work out

the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the Governor for his consideration.

If the Governor thinks the bill should become a law, he will sign it. If the Governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Three-fifths of the members elected to each House can override the veto. He can also veto specific items of an appropriation bill and he may reduce an appropriation. The Governor may also return a bill to the Legislature with specific recommendations for change, thereby obviating the need of vetoing the entire bill.

Note

A Legislative Directory containing the names and addresses of all members of the Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available. Requests should be directed to: Illinois State Medical Society, Regional Office, 520 S. Sixth St., Springfield 62701.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

1026 South Damen Avenue, Chicago
One North Old State Capitol Plaza, Springfield
Margaret M. Kennedy, *Director*

Director's Office

Dolores Reid, Deputy Director, Program Support Services
David Bankard, Deputy Director, Management Services
Neil Matlins, Deputy Director, Planning, Research and Evaluation
Bill Ryan, Deputy Director, Program Operations

Steve Bishop, Administrative Assistant to the Director (Chicago)
Cheryl Kahn, Administrative Assistant to the Director (Springfield)
Larry Rau, Legislative Liaison
Sharon Garber, Ombudsman (Springfield)
Reginald Patrick, Ombudsman (Chicago)

DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

401 S. Spring St., Springfield, 62706
160 N. La Salle St., Chicago, 60601
Robert A. DeVito, M.D., *Director*

Robert Y. Anderson, *Deputy Director*, Community Services
Richard E. Blanton, Ph.D., *Deputy Director*, Developmental Disabilities
Ivan Pavkovic, M.D., *Deputy Director*, Clinical Services and Programs
Roalda J. Alderman, *Superintendent*, Division of Alcoholism

Office of the Director

Robert E. Lanier, Special Assistant
Meyer Proctor, Chief, Office of Public Information

Alan E. Grischke, Manager, Division of Legal Services
William Fitzpatrick, Assistant Manager, Division of Legal Services
John Ryan, Legislative Liaison

STATUTORY BOARDS AND COUNCILS

1. Commission on Mental Health and Developmental Disabilities

Sen. John J. Nimrod, Glenview, *Chairman*
Hon. Michael Brady, Chicago
Judy Buchanan, Bloomington
Rep. Susan Catania, Chicago
Rep. Lee A. Daniels, Elmhurst
Sen. Vince DeMuzio, Carlinville
Honorable Joseph Fennessey, Ottawa
Sen. Vivian Veach Hickey, Rockford
Rep. Emil Jones, Jr., Chicago
Rep. John R. Lauer, Broadwell
William L. Mermis, Jr., Ph.D., Godfrey
Rep. Richard A. Mugalian, Palatine
Sen. Frank M. Ozinga, Evergreen Park
Mrs. Rose Poelvoorde, Silvis
Judge Joseph Schneider, Chicago
Hon. Esther Saperstein, Chicago
Rep. Helen Satterthwaite, Champaign
Sen. Jack Schaffer, Cary
Hon. Helmut Stolle, Chicago

2. Psychiatric Advisory Council

Roy R. Grinker, Sr., M.D., Chicago, *Chairman*
Robert A. DeVito, M.D., Chicago
George Pollock, M.D., Chicago
Jack Weinberg, M.D., Chicago
Jackson Smith, M.D., Hines
Harold M. Visotsky, M.D., Chicago

Daniel X. Freedman, M.D., Chicago
Ray Cunningham, M.D., Chicago
Jan Fawcett, M.D., Chicago
Frank T. Rafferty, M.D., Chicago
Hyman Muslin, M.D., Chicago
A. S. Norris, M.D., Springfield
Marshall Falk, M.D., Chicago

3. Advisory Council—PL 88-164 Construction Grants

Hiram Sibley, Chicago, *Chairman*
Judy Buchanan, Bloomington
Joseph M. Cronin, Ph.D., Springfield
Thomas P. deGraffenried, M.D., DeKalb
Mrs. John T. Even, Aurora
Naomi Hielt, Springfield
James Jeffers, Chicago
Margaret Kennedy, A.C.S.W., Springfield
Robert Norris, Evergreen Park
Robert O'Leary, Oakbrook
Samuel A. Patch, Chicago
Mrs. Wilbur F. Pell, Jr., Evanston
Paul Q. Peterson, M.D., Springfield
Arthur Quern, Springfield
Joseph H. Skom, M.D., Chicago
Hon. Helmut Stolle, Chicago
Thomas T. Tourlentes, M.D., Rock Island
Mrs. Elbert Tourangeau, Hinsdale
Bernice T. Van Der Vries, Evanston
Harold Ziebell, Springfield

NON-STATUTORY COUNCIL

1. Citizens' Advisory Council on Alcoholism

James West, M.D., Chicago
Fern Asma, M.D., Chicago
Richard Dechert, Decatur
G. W. Grawey, M.D., Peoria
La Verne Hawes, Chicago
Dwight Patrick, Decatur
James F. Griffin, Chicago
Paul B. Musgrove, Peoria
James Oughton, Dwight
W. David Steed, M.D., Oak Park
Walter H. Gregg, Ph.D., Evanston
William Thomas, M.D., Chicago
Richard M. Sanders, Ph.D., Carbondale
Msgr. Ignatius McDermott, Chicago

Philip Carlson, Peoria
Ralph Trask, Springfield
William L. Mermis, Jr., Ph.D., Godfrey
Margaret M. Hastings, Ph.D., Kenilworth
Robert Norris, Evergreen Park
Samuel A. Patch, Chicago
Albert Bonilla, Chicago
Honorable James Robinson, Danville
Brockman Schumacher, Ph.D., Carbondale
Thomas Hollen, Ph.D., Rockford
William Frayser, Broadview

2. Citizens' Advisory Council for Community Services

Arnold Levin, Ph.D., Chicago, *Chairman*
Paul B. Musgrove, Peoria

DANGEROUS DRUGS COMMISSION

The Drug Abuse Offense and Treatment Act of 1972 (PL 92-255) made federal funds available to the states for the purpose of combating drug abuse. In order to receive such funds, a state must submit a plan for implementing and evaluating an effective program for drug abuse prevention, treatment, and rehabilitation. Further, a single state agency must be established as the sole agency for the preparation and administration of the plan and allocation of funds.

The Dangerous Drugs commission also licenses and regulates all drug treatment, education, prevention and rehabilitation programs in the state, except those conducted within a licensed hospital. The Commission sets treatment standards and issues rules and regulations for the operation of drug abuse programs.

Treatment modalities of programs receiving Dangerous Drugs Commission funds include methadone maintenance, both residential and out-patient; drug free residential and out-patient therapy, and hot-line and crisis referral services. In addition to treatment funding, the Dangerous Drugs Commission supports drug counselor training for

previously drug dependent clients as well as clinical staff training.

Since reliable and timely data is essential in evaluating the effectiveness of drug abuse treatment and rehabilitation methods, the Information Services Division of the Commission continually collects, analyzes and applies data concerning clinical operations (medical workups, demographics) and regulatory methadone maintenance (counseling, toxicology, prescription dosages). The division also keeps a weekly statewide log for methadone clinics, a continuing inventory of drug abuse program resources, and a bank of research data on treatment modalities. All information is strictly confidential.

The Toxicology Division of the Dangerous Drugs Commission is the state laboratory facility which provides drug abuse tests to the state's total client population. The lab is subject to the regulations and standards set by the FDA, the National Institute of Drug Abuse and the Commission itself.

The Dangerous Drugs Commission is located at Marina City Office Building, 300 N. State St., Suite 1500, Chicago, 60610. Phone (312) 822-9860.

Robert A. deVito, M.D., Chicago, *Chairman*
Thomas Kirkpatrick, Jr., *Exec. Director*
Joseph Cronin, Springfield
Patricia D. Craig, R.N., Marion
Jerome Fahner, Springfield
Daniel X. Freedman, M.D., Chicago
James Jeffers, Chicago
Margaret Kennedy, A.C.S.W., Springfield
David M. Law, Washington
Paul Q. Peterson, M.D., Springfield
Arthur Quern, Springfield
Charles Rowe, Springfield

Dangerous Drugs Advisory Council

Rep. L. Michael Getty, Dolton, *Chairman*
Mrs. Roalda J. Alderman, Chicago
Joan Anderson, Springfield
William D. Barta, Waukegan
Susan M. Barton-Gatlin, Springfield
David Blumenfeld, Esq., Chicago
Murray C. Brown, M.D., Chicago

Emanuel M. Cannonito, Esq., Blue Island
Bernard Carey, Esq., Chicago
Sen. John A. Davidson, Springfield
Hon. John D'Arco, Chicago
Ms. Joan Elbow, Galesburg
Norman Garfinkel, Oak Park
Repr. Giddy Dyer, Hinsdale
Donald R. Gronewald, R.Ph., Washington
Repr. George Hudson, Hinsdale
Sam Lazich, Park Ridge
Michael M. Mihm, Esq., Peoria
Sen. Dawn Clark Netsch, Chicago
Robert W. O'Leary, Esq., Oak Brook
Don Paull, Ph.D., Chicago
Sen. James Philip, Downers Grove
James M. Rochford, Chicago
David B. Selig, Esq., Wilmette
Jay Ulaneck, Chicago
Hon. Leroy M. VanDayne, Joliet
J. A. Wells, M.D., Maywood
George Wilkins, M.D., Chicago

DEPARTMENT OF PUBLIC AID

316 South 2nd St., Springfield
Arthur F. Quern, *Director*

The Illinois Department of Public Aid administers the federally aided public assistance programs: Aid to Families with Dependent Children; Medical Assistance; and provides supplemental financial grants to eligible aged, blind, or disabled persons. In addition, the department allocates state funds to qualified and requesting governmental units for the administration of General Assistance; and in cooperation with the U.S. Department of Agriculture, administers the Food Stamp program.

Administrative Staff

David L. Daniel, *Assistant Director*

Robert G. Wessel, Chief Assistant to the Director

Mr. Norman Ryan, Deputy Director, Division of Financial Management; General Services Administrator

Mr. Jeffrey C. Miller, Deputy Director, Division of Medical Programs

Mr. Jesse B. Harris, Deputy Director, Division of Programs & Services

Michael Belletire, Deputy Director, Office of Social services

Verne H. Evans, General Counsel

Johnetta W. Jordan, Chief, Office of Public Information

Gerald D. Slavens, Chief, Office of Systems Analysis and Quality Control

Joseph L. Ekiss, Chief, Office of Personnel and Administrative Services

Legislative Advisory Committee on Public Aid

Senator Don A. Moore, Midlothian, *Chairman*
Representative Fred J. Smith, Chicago, *Vice-Chairman*
Senator Richard H. Newhouse, Chicago
Senator Frank M. Ozinga, Evergreen Park
Senator Robert T. Lane, Chicago Heights
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Public Health Laboratories

2121 West Taylor, Chicago, 60612

134 North 9th Street, Springfield 62706

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POISON CONTROL CENTERS IN ILLINOIS

For information contact:
Robert S. Nash, Chief of Clinical Services
Division of Emergency Medical Services & Highway Safety
Illinois Department of Public Health
535 W. Jefferson
Springfield, 62761
Phone: (217) 782-5278

APPROVED RENAL DIALYSIS FACILITIES, CENTERS AND DIRECTORS

Illinois Department of Public Health
Division of Disease Control

For information contact:

Mrs. Ruth S. Shriner, ACSW—Coordinator Direct Services
Programs, Illinois Department of Public Health
Room 150, 535 West Jefferson Street, Springfield 62706
Phone (217) 782-3303

DEPARTMENT OF REGISTRATION AND EDUCATION

628 East Adams Street, Springfield
55 East Jackson Boulevard, Chicago

Joan G. Anderson, *Director*
Thomas Ortiger, *Assistant Director*
Jerry D. Sternstein, *Deputy Director-Licensing*
Jacob M. Shapiro, *Chief Counsel*
Algis Augustine, *Chief Regulatory Officer*

The department is primarily concerned with the registration, licensing and enforcement of 34 laws governing the different professions, trades and occupations, including the Medical Practice Act.

The Medical Examining Committee appointed by the director of the department operates within the framework of the act and is charged with the responsibility of

supervising examinations for licensure and making recommendations to the Director to grant or refuse to grant licenses. The Medical Disciplinary Board hears complaints for revocation and suspension of licenses and recommends disciplinary action to the Director.

Medical Examining Committee

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MEDICAL PRACTICE ACT

LICENSING AND ENFORCEMENT PROCEDURES

Illinois statutes provide for licensing of physicians to practice medicine "(1) in all of its branches, and (2) licensing of those persons to treat human ailments without the use of drugs or medicine and without operative surgery."

The Medical Practice Act states, "no person shall practice medicine, or any of its branches, or midwifery, or any system or method of treating human ailments without the use of drugs or medicines and without operative surgery, without a valid, existing license so to do." Applicant for license must pass an examination of his qualifications which must be satisfactory to the Department of Registration and Education.

Service on medical committees—Exemption from civil liability. § 2b. While serving upon any Medical Utilization Committee, Medical Review Committee, Patient Care Audit Committee, Medical Care Evaluation Committee, Quality Review Committee, Credential Committee, Peer Review Committee or any other committee whose purpose is internal quality control or medical study to reduce morbidity or mortality, or for improving patient care within a hospital duly licensed under the Hospital Licensing Act, or for the purpose of professional discipline, any person serving on such committee, and any person providing service to such committees shall not be liable for civil damages as a result of his acts, omissions, decisions, or any other conduct in connection with his duties on such committees, except those involving willful or wanton misconduct. Amended by P.A. 79-1434 § 7, eff. Sept. 19, 1976.

This act does not prohibit the practice of medicine by a person who is licensed to practice medicine in all of its branches in any other state of the United States or the District of Columbia who has applied in writing to the Department, in form and substance satisfactory to the Department, for a license to practice medicine in all of its branches and has complied with all of the provisions of Section 13, except the passing of an examination which may be given under Section 13, until:

- (a) the expiration of 6 months after the filing of such written application, or
- (b) the decision of the Department that the

applicant has failed to pass an examination within 6 months or failed without an approved excuse to take an examination conducted within 6 months by the Department, or

(c) the withdrawal of the application. (Added by Act approved July 26, 1971)

Any person licensed under this Act who dispenses any drug or medicine shall affix to the box, bottle, vessel or package containing the same a label indicating (a) the date on which such drug or medicine is dispensed; (b) the last name of the person dispensing such drug or medicine; (c) the directions for use thereof; and (d) the proprietary name or names or, if there is none, the established name or names of the drug or medicine, the dosage and quantity, unless the person dispensing the drug or medicine determines that the health of the person to whom the drug or medicine is dispensed requires that such information be omitted. This Section shall not apply to drugs or medicines in a package which bears a label of the manufacturer containing information describing its contents which is in compliance with requirements of the Federal Food, Drug and Cosmetic Act and the Illinois Food, Drug and Cosmetic Act and which is dispensed without consideration by a practitioner licensed under this Act. "Drug" and "medicine" have the meaning ascribed to them in the "Pharmacy Practice Act," approved July 11, 1955, as now or hereafter amended. (Added by Act approved September 24, 1971)

Minimum standards of professional education. Except as provided in Section 9a of this Act, the minimum standards of professional education to be enforced by the department in conducting examinations and issuing licenses shall be as follows:

1. *Practice of Medicine.* For the practice of medicine in all of its branches:

(a) For an applicant who is a graduate of a medical college before the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to graduation a 4 years' course of instruction of not less than 9 months each, in such medical college, or its equivalent, the time elapsing between the beginning of

the first year and the ending of the fourth year having been not less than 40 months, and which was reputable and in good standing in the judgment of the department; and prior to taking such examination said applicant must present proof that he has completed a 4 years' course of instruction in a high school or its equivalent as determined by an examination conducted by the department.

(b) For an applicant who is a graduate of a medical college after the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to admission thereto 2 years' course of instruction in a college of liberal arts, or its equivalent, or in such medical college, and a course of instruction in a medical college in the treatment of human ailments, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, and in addition thereto, a course of clinical training of not less than 12 months in a hospital, such college of liberal arts, medical college and hospital having been reputable and in good standing in the judgment of the department.

The time requirement of not less than 132 weeks within a period of 35 months, set forth above, may be reduced by the department upon recommendation of the Dean of the medical school in the case of programs involving students with advanced standing. (added by Act approved July 26, 1971).

(c) For an applicant who is a graduate of a medical college or school in another country; that such applicant was a resident of this State for a period of five years prior to matriculating in such medical college or school; that such applicant completed a required course of instruction in the treatment of human ailments as offered by such college or school of medicine, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months; that such applicant has completed a minimum of three years course of instruction in an accredited college of liberal arts or its equivalent; that such applicant may be placed by an Illinois medical school and submit to such testing procedures, including use of nationally recognized medical student tests and/or tests devised by the individual medical school, to determine equivalency of education compared to state norms, such testing could be utilized in placement of such applicant at a level appropriate to educational achievement; that such applicant may be placed by an Illinois medical school into the appropriate level of medical school, thru internship training, provided that applicant agrees to pay, either by a scholarship or some other personal means, such tuition and fees necessary to complete medical education, and provided that such applicant signs a statement in a form to be determined by the Department that upon successful completion of all licensure requirements applicant intends to practice medicine in this State. Upon completion of such course or activity of didactic and medical training as specified by an accepting medical school, applicant shall be eligible for award of an M.D. degree and examination and

licensing for the practice of medicine in all of its branches as provided in this act and upon payment of the fee provided in paragraph (a) of sub-section 4 of Section 4 of this Act.

(d) Until September 1, 1978, for an applicant who has studied medicine at a medical college or school located outside the United States; that such applicant has completed all of the formal requirements of a foreign medical school except internship and/or social service, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months; that such applicant has completed a minimum of 3 years course of instruction in an accredited college of liberal arts or its equivalent; that such applicant has submitted an application to a medical school recognized by the Department and submitted to such evaluation procedures, including use of nationally recognized medical student tests and/or tests devised by the individual medical school and that such applicant has satisfactorily completed one academic year of supervised clinical training under the direction of such medical school; and, after completion of said academic year of supervised clinical training, that such applicant has satisfactorily completed twelve months of post graduate training in an approved hospital having been reputable and in good standing in the judgment of the Department; and provided that such applicant sign a statement and a form, to be determined by the Department, that upon successful completion of all licensure requirements, applicant intends to practice medicine in this state. Upon completion of such course or activity of didactic and medical training as specified by an accepting medical school, applicants shall be eligible for examination and licensing for the practice of medicine in all of its branches as provided in this Act and upon payment of the fee provided in paragraph (a) of sub-section 4 of Section 4 of this Act.

Until September 1, 1978, satisfaction of the requirements of this sub-section shall be in lieu of the completion of any foreign internship and/or social service requirements, and no such requirements shall be a condition of licensure as a physician in this State.

Until September 1, 1978, satisfaction of the requirements of this sub-section shall be in lieu of certification by the Educational Council for Foreign Medical Graduates, and such certification shall not be a condition of licensure as a physician in this State for candidates who have completed the requirements of this sub-section.

Until September 1, 1978, no hospital licensed by the State, or operated by the State or political subdivision thereof, or which receive State financial assistance, directly or indirectly, shall require an individual who at the time of his enrollment in a medical school outside the United States is a citizen of the United States, to satisfy any requirement other than those contained in this sub-section prior to commencing an internship or residency.

Until September 1, 1978, a document granted by a medical school located outside the United States which certifies completion of all of the formal training requirements of such foreign medical school except internship and/or social service; and satisfactory completion of the examination and academic

year of supervised clinical training at a medical school recognized by the Department referred to in this sub-section shall be deemed the equivalent of the degree of Doctor of Medicine for purposes of licensure and practice as a physician in this State and shall possess all the rights and privileges thereof.

The Illinois Board of Higher Education may make grants to Illinois Medical Schools, public and private, for each applicant who commences his academic year of supervised clinical training under the direction of said medical school. Preference shall be given in the award of these grants to Illinois residents. The Illinois Board of Higher Education shall by regulation adopt reasonable guidelines for the distribution of funds authorized by this Act. (Added by Act approved Sept. 7, 1974).

2. *Treating human ailments without drugs or medicines and without operative surgery.* For the practice of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery:

(a) For an applicant who was a resident student and who is a graduate before July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments, which he specifically designated in his application as the one he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to graduation a 3 years' course of instruction of not less than 6 months each, the time elapsing between the beginning of the first year and the ending of the third year having been not less than 22 months, and which are reputable and in good standing in the judgment of the department and prior to taking the examination the applicant must present proof that he has completed a 4 years' course of instruction in high school, or its equivalent, as determined by an examination conducted by the department.

(b) For an applicant who was a resident student and who is a graduate after July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments which he specifically designated in his application as the one which he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to admission thereto a 4 years' course of instruction in a high school, and as a prerequisite to graduation therefrom a course of instruction in the treatment of human ailments, of not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months except that as to students matriculating or entering upon a course of study of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery during the years 1940, 1941, 1942, 1943, 1944, 1945, 1946 and 1947, the said elapsed time shall be not less than 32 months, such high school and such school,

college, institution having been reputable and in good standing in the judgment of the department.

(c) For an applicant who is a matriculant in a chiropractic college after September 1, 1969, that such applicant shall be required as a prerequisite for admission to examine for licensure, to complete a 2 years' course of instruction in a liberal arts college or its equivalent, and a course of instruction in a chiropractic college in the treatment of human ailments, such course as a prerequisite to graduation therefrom having been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, such college of liberal arts and chiropractic college having been reputable and in good standing in the judgment of the Department.

3. *Midwifery.* For the practice of midwifery: That he be a graduate of a college of midwifery which requires as a prerequisite to admission thereto, a one year's course of instruction in a high school or its equivalent, and required as a prerequisite to graduation, a one year's course in such college of midwifery, the time actually spent under instruction in such college of midwifery to have been not less than 12 months; such high school or equivalent school, and such college of midwifery having been in good standing in the judgment of the department.

Without prejudice to licenses heretofore issued under this section, no further licenses shall be issued under this section after the effective date of this amendment. As amended by act approved Sept. 7, 1974, and March 4, 1975.

All examinations provided for by the Medical Practice Act shall be conducted by the Department of R&E. Examinations of applicants who seek to practice medicine in all of its branches shall embrace the subjects of which knowledge is generally required of candidates for the degree of Doctor of Medicine by reputable medical colleges in the U.S., and shall be such in the judgment of the Department of R&E that as will determine the qualifications of applicants to practice medicine in all of its branches.

Every license issued under the Act expires on July 1 of each even numbered year. Every licensee under the Act may, biennially during the month of June of each even-numbered year, renew his license upon paying to the Department a renewal fee of \$40.

CONTINUING EDUCATION

The Department, based on the written recommendation of the Examining Committee, shall promulgate mandatory requirements of continuing education for persons licensed pursuant to this Act. In establishing such recommendations, the Committee shall:

- (1) Develop practical and meaningful criteria for defining and describing continuing education requirements which meet, but are not limited to, the following specifications:

- (a) Readily available to all practicing physicians in Illinois without undue commitment of time away from practice and expense on the part of the practitioner.
- (b) Compatible with existing requirements of licensing agencies in other states.
- (c) Compatible with the requirements of medical specialty boards for recertification of specialty status.
- (d) Compatible with the continuing education requirements developed by national medical specialty societies.
- (e) Compatible with continuing education programs and requirements that are developed in federally mandated peer review programs and as a part of Professional Standards Review Organizations.
- (f) Provides for differing requirements for licensees engaged in other than direct patient care (example: educators, researchers and those engaged in medical administration).
- (g) Provides for compatible requirements for licensees in the federal uniformed services, those engaged in formal residency and fellowship training programs, and licensees operating under hospital permit licensure.
- (2) Conceive, develop and evaluate procedures, materials and systems to carry out the administrative requirements of this legislation which include, but are not limited to, the following:
 - (a) Procedures for prompt and fair evaluation of reports of educational achievement submitted by licensees.
 - (b) Requirements and position descriptions for personnel engaged in reviewing and evaluating reports and continuing educational achievements submitted by licensees.
 - (c) A data recording system for gathering, analyzing, storing and retrieving information on individual licensee educational accomplishments.
 - (d) Provision for licensee to appeal adverse actions and temporary exemptions from requirements under unusual circumstances.
 - (e) Exemption from legal prosecution of all persons responsible for action taken under the program.
 - (f) Establishment of realistic budgeting and cost requirements for the personnel, and operational funds necessary to plan, develop and operate the program.
 - (g) Procedures for surveying and evaluating the effectiveness of the program.
 - (h) Orderly procedures for adequate notice to licensee of pending action that may result in non-renewal of license, including provisions for consultation and assistance in time for him to meet the requirements of this Act.
- (3) Develop adequate protection for information about licensee participation in continuing education as it pertains to all aspects of practice liability and the licensee's public image and his relationships with individual patients.
- (4) Develop an advisory panel for each category of licensee to advise and assist the department in development and application of continuing education criteria, administrative procedures

and policy.

- (5) Develop procedures for assuring that the educational opportunities available to licensees for fulfilling the requirements of this act are of appropriate scope, variety, depth and of high quality.

The Department shall enforce these requirements; however, the Department shall be empowered to waive enforcement of these requirements in localities where it is demonstrated that the absence of opportunities for such education would interfere with the adequacy of medical services in that locality.

Added by Act eff. July 1, 1976.

REVOCATION AND SUSPENSION OF LICENSE OR CERTIFICATE

The Department may revoke, or suspend, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license, certificate or state hospital permit of any person issued under this Act or under any other Act in this State to practice medicine, to practice the treatment of human ailments in any manner or to practice midwifery, or may refuse to grant a license, certificate or state hospital permit under this Act or may grant a license, certificate or state hospital permit on a probationary status subject to the limitations of the probation, and may cause any license or certificate which has been the subject of formal disciplinary procedure to be marked accordingly on the records of any county clerk upon the following grounds:

- 1. Conviction of procuring or attempting or aiding to procure such an abortion as was made unlawful at the time under the Criminal Code of this State;
- 2. Conviction in this or another state of any crime which is a felony under the laws of this state or conviction of a felony in a federal court, unless such person demonstrates to the Department that he has been sufficiently rehabilitated to warrant the public trust; (as amended by Act approved August 19, 1975);
- 3. Gross or repeated malpractice resulting in serious injury or death of a patient (as amended by Act approved August 19, 1975).
- 4. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud, or harm the public;
- 5. Obtaining a fee, either directly or indirectly, either in money or in the form of anything else of value or in the form of financial profit as personal compensation, or as compensation, charge, profit or gain for an employer or for any other person or persons, on the fraudulent representation that a manifestly incurable condition of sickness, disease or injury or any person can be permanently cured;
- 6. Habitual intemperance in the use of ardent spirits, narcotics, or stimulants to such an extent as to incapacitate for performance

of professional duties;

7. Holding one's self out to treat human ailments under any name other than his own, or the personation of any other physician;
8. Employment of fraud, deception or any unlawful means in applying for or securing a license, certificate, or state hospital permit to practice the treatment of human ailments in any manner, to practice midwifery, or in passing an examination therefor, or willful and fraudulent violation of the rules and regulations of the department governing examinations;
9. Holding one's self out to treat human ailments by making false statements, or by specifically designating any disease, or group of diseases and making false claims of one's skill or the efficacy or value of one's medicine, treatment or remedy therefor;
10. Professional connection or association with, or lending one's name to, another for the illegal practice by another of the treatment of human ailments as a business, or professional connection or association with any person, firm, or corporation holding himself, themselves, or itself out in any manner contrary to this Act;
11. Revocation or suspension of a medical license in a sister state;
12. A violation of any provision of this Act or of the rules and regulations formulated for the administration of this Act;
13. Except as otherwise provided in Section 16.01, advertising or soliciting by himself or through another, by means of hand bills, posters, circulars, stereopticon slides, motion pictures, radio, newspapers or in any other manner for professional business."
14. Directly or indirectly giving to or receiving from any physician, person, firm or corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered. Nothing contained in this subsection prohibits persons holding valid and current licenses under this Act from practicing medicine in partnership under a partnership agreement or in a corporation authorized by "The Medical Corporation Act" as now or hereafter amended or as an association authorized by "The Professional Association Act" as now or hereafter amended, or under "The Professional Corporation Act" as now or hereafter amended, from pooling, sharing, dividing or apportioning the fees and monies received by them or by the partnership, corporation or association in accordance with the partnership agreement or the policies of the Board of Directors of the corporation or association. Nothing contained in this subsection shall abrogate the right of two or more persons holding valid and current licenses under this Act to receive adequate compensation for concurrently rendering professional services to a patient and divide a fee: provided, the patient has full knowledge of the division, and

provided that the division is made in proportion to the services performed and responsibility assumed by each.

15. A finding by the Committee that the registrant after having his license placed on probationary status violated the terms of the probation.
16. All advertising of medical business which is intended, or has a tendency, to deceive the public or impose upon credulous or ignorant persons and so be harmful or injurious to public morals or safety.
17. All advertising of any medicine or of any means whereby the monthly menses of women can be regulated or reestablished if suppressed.
18. Abandonment of a patient.
19. The use of prescription for use of narcotics or controlled substances (designated products) in any way other than for therapeutic purposes.
20. Promotion of the sale of drugs, devices, appliances or goods provided for a patient in such manner as to exploit the patient for financial gain of the physician.
21. Offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine, or the treating, operating or prescribing for any human condition by a method, means or procedure which the licensee refuses to divulge upon demand of the Department of Registration and Education.
22. Immoral conduct in practice as a physician, or repeated acts of gross misconduct.
23. Willfully making or filing false records or reports in his practice as a physician.
24. Willful omission to file or record, or willfully impeding the filing or recording or inducing another person to omit to file or record medical reports as required by law.
25. Solicitation of professional patronage by any corporation, agents or persons, or profiting from those representing themselves to be agents of the licensee.
26. Gross and willful and continued overcharging for professional services, including filing false statement for collection of fees for which services are not rendered.
27. Professional incompetence as manifested by poor standards of care or mental incompetency as declared by a court of competent jurisdiction (as amended by Act approved August 19, 1976).
28. Physical illness, including, but not limited to, deterioration through the aging process, or loss of motor skill which results in a physician's inability to practice medicine with reasonable judgment, skill or safety.

All proceedings to suspend, revoke, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to a license, certificate or state hospital permit on any of the foregoing grounds, except the ground numbered 8 (fraudulent groups expected) must be commenced within 3 years next after the conviction or commission of any of the acts described therein, except as otherwise provided by law; but the time during which the holder of the license, certificate or state hospital permit was without the State of Illinois shall not be included within the 3 years.

The entry of an order or judgment by any circuit court establishing that any person holding a license, certificate or state hospital permit under this Act is a person in need of mental treatment operates as a suspension of that license, certificate or state hospital permit. That person may resume his practice only upon a finding by the Medical Disciplinary Board that he has been determined to be recovered from mental illness by the court and upon the Board's recommendation that he be permitted to resume his practice.

Section 16.01. Any person licensed under this Act may list his name, title, office hours, address, telephone number and any specialty in professional and telephone directories; may announce by way of a professional card not larger than 3½ inches by 2 inches, only his name, title, degree, office location, office hours, phone number, residence address and phone number and any specialty; may list his name, title, address and telephone number and any specialty in public print limited to the number of lines necessary to state that information; may announce his change of place of business; absence from, or return to business in the same manner; or may issue appointment cards to his patients, when information thereon is limited to the time and place of appointment and that information permitted on the professional card. Listings in public print, in professional and telephone directories, or announcements of change of place of business, absence from, or return to business, may not be made in bold faced type.

MEDICAL DISCIPLINARY BOARD

There has been created the Illinois State Medical Disciplinary Board, which consists of 7 members, appointed by the Governor by and with advice and consent of the Senate. All shall be residents of the State, not more than 4 of whom shall be members of the same political party. Five members shall be physicians licensed to practice medicine in all of its branches in Illinois. One member shall be an Illinois physician possessing the degree of doctor of osteopathy. One member shall be a person licensed in Illinois and possessing a chiropractor's degree.

a. Of the members of the Board first appointed, two shall be appointed for terms of 2 years; two shall be appointed for terms of 3 years, and three shall be appointed for terms of 4 years. Upon the expiration of the term of any member, his successor shall be appointed for a term of four years by the Governor by and with the advice and consent of the Senate. The Governor shall fill any vacancy for the remainder of the unexpired term by and with the advice and consent of the Senate. Upon recommendation of the Board, any member of the Board may be removed by the Governor for misfeasance, malfeasance, or willful neglect of duty after notice and a public hearing unless such notice and hearing shall be expressly waived in writing. Each member shall serve on the Board until his successor is appointed and qualified. No member of the Board shall serve more than two consecutive

four year terms.

In making appointments the Governor shall attempt to insure that the various social and geographic regions of the State of Illinois are properly represented.

In making the designation of persons to act for the several professions represented on the Board, the Governor shall give due consideration to recommendations by members of the respective professions and by organizations therein.

- b. The Board shall annually elect one of its members as chairman, one as vice chairman and one as secretary. No officer shall be elected more than twice in succession to the same office. Each officer shall serve until his successor has been elected and qualified.
 - c. The secretary shall keep a record of the proceedings of the Board and shall be custodian of all books, documents and papers filed with the Board, including the minute book or journal of the Board. The secretary or other persons authorized by the Board may cause copies to be made of all minutes and other records and documents of the Board and may give certificates of the Board to the effect that such copies are true copies, and all persons dealing with the Board may rely upon such certificates.
 - d. Four members of the Board shall constitute a quorum. A vacancy in the membership of the Board shall not impair the right of a quorum to exercise all the rights and perform all the duties of the Board. Any action taken by the Board under this Act may be authorized by resolution at any regular or special meeting and each such resolution shall take effect immediately. The Board shall meet at least quarterly. The Board is empowered to adopt all rules and regulations necessary and incident to the powers granted to it under this Act.
 - e. Each member, and member-officer, of the Board shall receive a per-diem stipend as the Director of the Department of Registration and Education hereinafter referred to as the Director, shall determine. Each member shall be paid his necessary expenses while engaged in the performance of his duties.
 - f. The Director shall in conformity with the "Personnel Code," as now or hereafter amended, select a medical coordinator, who shall not be a member of the Board. The medical coordinator shall be a physician licensed to practice medicine in all of its branches, and the Director shall set his rate of compensation. The medical coordinator shall be the chief enforcement officer of the Medical Practice Act and shall serve at the will of the Board.
- The Director shall employ, in conformity with the Personnel Code, not less than one (1) full time investigator for every 5000 physicians licensed to practice medicine in the State. Each investigator shall be a college graduate with at least two years' investigative experience or one year advanced medical education. Upon the written request of the Board, the Director shall employ, in conformity with the Personnel Code, such other professional, technical, investigative, and clerical help, either as a full or part-time basis as the Board deems necessary for the proper performance of its duties. All employees

of the Board shall be directed by, and answerable to, the Board with respect to their duties and functions.

- g. Upon the specific request of the Board, signed by either the chairman, vice chairman, or medical coordinator of the Board, the Bureau of Drug Compliance, the Office of Professional Supervision of the Department of Registration and Education, the Illinois Law Enforcement Commission, the Illinois Bureau of Investigation, the Illinois Legislative Investigating Commission shall.

(1) Make available any and all information that they shall have in their possession regarding a particular case then under investigation by the Board.

- h. Members of the Board shall be immune from suit in any action based upon any disciplinary proceedings of other acts performed in good faith as members of the Board.

Added by Act eff. Nov. 21, 1975.

ECFMG Requirements

The Education Council for Foreign Medical Graduates (ECFMG) commenced operations in October, 1957. Sponsors of this agency are the American Hospital Association, American Medical Association, Association of American Medical Colleges, and Federation of State Medical Boards of the United States. ECFMG gives two examinations a year to foreign medical graduates. The examinations test the graduate's general knowledge of medicine and command of English.

Persons successfully passing this examination are granted an ECFMG certificate. This certificate in the State of Illinois is **not** a substitute for nor is it the equivalent of licensure to practice medicine. It simply indicates that the holder's command of English has been tested and found adequate for assuming an internship in an American hospital. The holder of such a certificate may not practice medicine in any degree in a hospital in Illinois unless he is within one of the categories outlined above.

Offenses Listed

An unlicensed person who commits any of the following acts regardless of whether the same be committed within or without a hospital is guilty of practicing medicine without a license—a criminal offense:

1. Hold himself out to the public as being engaged in the diagnosis or treatment of ailments of human beings.
2. Suggest, recommend or prescribe any form of treatment for the palliation, relief or cure of any physical or mental ailment of a person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever.
3. Diagnosticate or attempt to diagnosticate any ailment or supposed ailment of another.
4. Operate upon, profess to heal, prescribe for, or otherwise treat any ailment, or supposed ailment of another.

5. Maintain an office for examination or treatment of persons afflicted, or alleged or supposed to be afflicted, by any ailment.

6. Attach the title Doctor, Physician, Surgeon, M.D., or any other word or abbreviation to his name, indicative that he is engaged in the treatment of human ailments as a business.

(Medical Practice Act. [Chp. 91, Sec. 16i, Paragraph 24, 1975 Rev. Stat.])

Manifestly, the enforcement of the Medical Practice Act with respect to the elimination of unlicensed persons practicing medicine in a hospital is dependent upon co-operation by responsible persons within the hospital. It should be noted that lack of co-operation or failure to meet responsibilities can in a proper case be translated into criminal liability and disciplinary action resulting in revocation or suspension of a license to practice medicine as follows:

1. The unlicensed person practicing medicine is committing a criminal offense.
2. A hospital administrator who assigns an unlicensed person to duties which involve his practicing medicine may subject himself to the criminal offense of aiding and abetting such unlicensed person to illegally practice medicine, and the same may be true of a hospital chief of staff or department head if in the nature of his duties he is directly responsible for assigning such duties to the unlicensed person.
3. A licensed doctor may have his license suspended or revoked if he has professional connection or association with another who is illegally practicing medicine. A chief of staff who knowingly allows such person to illegally practice medicine, or in a proper case, any member of the medical staff of a hospital may subject himself to disciplinary action against his license.
4. A licensed doctor may have his license suspended or revoked for unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public.

A member of the medical staff of a hospital may place himself within such conduct if he neglects, fails or refuses to fulfill his responsibilities while on emergency room call.

Physician's Assistant Act

Section 1. The purpose and legislative intent of this Act is to encourage and promote the more effective utilization of the skills of physicians by enabling them to delegate certain health tasks to physician's assistants where such delegation is consistent with the health and welfare of the patient and is conducted at the direction of and under the responsible supervision of the physician.

Section 2. This Act shall be known and may be cited as the "Physician's Assistants Practice Act."

Section 3. "Physician's assistant" means any person not a physician who is certified to perform medical procedures under the supervision of persons licensed to practice under "The Medical Practice Act." A physician's assistant may perform such medical procedures within the specialty of the supervising physician, except that such physician shall exercise such direction, supervision and control over such physician's assistants as will assure that patients receiving medical care from a physician's assistant shall receive medical care of the highest quality. Physician's assistants shall be capable of performing a variety of tasks within the specialty of medical care under the supervision of a physician, although the physician's assistant does not possess the level of medical knowledge necessary to integrate and interpret findings. Physician's assistants cannot exercise independent judgment for purposes of diagnosis and treatment of patients. Nothing in this Act shall be construed as relieving any physician of the professional or legal responsibility for the care and treatment of persons attended by himself or by physician's assistants under his supervision. Physician's assistants shall have only those powers and rights set forth in this Act and the exercise of any powers beyond those set forth shall constitute a violation of this Act.

Section 4. No physician's assistant shall use the title of doctor or associate with his name any other term which would indicate to other persons that he is qualified to engage in the general practice of medicine. A physician's assistant shall not be allowed to bill patients or in any way to charge for services. Nothing in this Act, however, shall be so construed as to prevent the employer of a physician's assistant from charging for services rendered by the physician's assistant. The physician shall file with the Department notice of employment and discharge of the physician's assistant at the time of said employment or discharge.

Section 5. No more than one physician's assistant shall be employed by a physician. Physician's assistants shall be employed only under the supervision of persons licensed to practice under "The Medical Practice Act" and engaged in private clinical practice, or in clinical practice in public health or other community health facilities.

Section 6. Each applicant for a physician's assistant certificate shall:

1. Make application for examination on forms prepared and furnished by the Department of Registration and Education.

2. Submit evidence under oath satisfactory to the Department that:

- (a) He is 21 years of age or over;
- (b) He is of good moral character;
- (c) He has the preliminary and professional education required by this Act;
- (d) He is free of contagious diseases.

3. Designate specifically the name, location, and kind of professional schools, colleges, or institutions attended and the courses which he has satisfactorily completed.

4. Pay to the Department of Registration and Education at the time of application, an examination fee of \$25. The fee for subsequent renewal of a certificate without lapse shall be \$15.

Section 7. Except as otherwise provided in this Act, the minimum standards of educational requirements prior to the taking of an examination shall

consist of the following:

(a) Successful completion of a 4 year course of instruction in a high school, or its equivalent, as determined by the examining committee; and

(b) Successful completion of a specialized course for physician's assistants consisting of not less than 20 months instruction in any 2 year period; such course and the institution or school offering the same shall be approved by the examining committee provided for in this Act.

The examining committee shall have the power to waive the specialized training provided for in this Section, if the committee determines that any prior training and experience of the applicant is the equivalent of such specialized training.

Section 8. Registered nurses in the State of Illinois may take such examination without completing any additional courses of study and shall be issued a certificate upon the passage of such examination.

Section 9. Subject to the provisions of this Act, the Department of Registration and Education shall:

1. Promulgate rules approved by the examining committee setting forth standards to be met by a school or institution offering a course of training for physician's assistants prior to approval of such school or institution.

2. Promulgate rules approved by the examining committee setting forth uniform and reasonable standards of instruction, including but not limited to specific subjects taught, to be met prior to approval of such course of instruction for physician's assistants.

3. Determine the reputability and good standing of such schools or institutions and their course of instruction for physician's assistants by reference to compliance with such rules, provided that no school of physician's assistants that refuses admittance to applicants solely on account of race, color, sex, or creed shall be considered reputable and in good standing.

4. Prescribe rules for examining candidates for a certificate as physician's assistant.

5. All examinations provided for by this Act shall be conducted under rules and regulations prescribed by the Department of Registration and Education. Examinations shall be held at least 3 times a year at times and places to be determined by the Department.

No rule or regulation shall be adopted under this Act which allows a physician's assistant to perform any act, task or function primarily performed in the lawful practice of optometry under "The Illinois Optometric Practice Act," approved June 15, 1951, as amended.

Section 10. Upon the satisfactory completion of application and examination procedures and compliance with the applicable rules and regulations of the Department of Registration and Education, the Department shall issue a physician's assistant certificate to the qualifying applicant.

Section 11. The Medical Examining Committee of the Department of Registration and Education as provided in Section 60-a of "The Civil Administrative Code of Illinois," approved March 17, 1917, as amended, may revoke or withdraw the certificate issued under this Act upon any of the following grounds:

1. Conviction in this or another state of any crime which is a felony under the law of this State, or conviction of a felony in a federal court;

2. Gross malpractice resulting in permanent injury or death of a patient;

3. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public;

4. Habitual intemperance in the use of alcohol, narcotics or stimulants to such an extent as to incapacitate for performance of professional duties.

5. Employment of fraud, deception or any unlawful means in applying for or securing a certificate as a physician's assistant;

6. Exceeding the authority delegated to him by his employing physician;

7. A violation of any provisions of this Act or of the rules and regulations formulated for its administration.

Section 12. No action of a disciplinary nature which is predicated on charges alleging unethical or unprofessional conduct of a person who practices as a physician's assistant and which can be reasonably expected to affect adversely that person's maintenance of his present, or his securing of future, employment as such a physician's assistant may be taken by the Department of Registration and Education, by any association, or by any person unless the physician's assistant against whom such charges are made is afforded the right to be represented by legal counsel of his choosing and to present any witness, whether an attorney or otherwise, to testify on matters relevant to such charges.

Section 13. Certificates may be revoked or suspended only in the manner provided by Section 60b through 60h inclusive of "The Civil Administrative Code of Illinois," approved March 7, 1917, as now or hereafter amended.

Section 14. All final administrative decisions of the Department of Registration and Education are subject to judicial review pursuant to the provisions of the "Administrative Review Act," approved May 8, 1945, and all amendments and modifications thereof, and the rules adopted pursuant thereto. The term "administrative decision" is defined in Section 1 of the "Administrative Review Act."

Section 15. All certificates issued under this Act must be renewed every 2 years after their issuance and the examining committee may require a physician's assistant to submit to a mental or physical examination at any time felt necessary by the examining committee.

Section 16. No person shall use the title or perform the duties of "physician's assistant" unless he

is a qualified holder of a certificate as provided in this Act. A certified physician's assistant shall wear on his person a visible identification indicating that he is certified as a physician's assistant while acting in the course of his duties.

Section 17. The Medical Examining Committee of the Department of Registration and Education shall review the provisions of this Act to determine its effectiveness and accomplishments and shall solicit the cooperation and advice of such public and private agencies as the Committee may deem proper. The Committee shall report its findings and recommendations to the Governor and the General Assembly on January 1, 1980.

Section 18. This Act takes effect July 1, 1976.

Section 19. This Act is repealed on June 30, 1981.

TWO-YEAR TEMPORARY CERTIFICATE OF REGISTRATION (RESIDENCIES)

Senate Bill 1164, recently signed into law by Gov. James R. Thompson, brings about some changes in the Illinois Medical Practice Act as it pertains to temporary licensure. Section 11a of the Act was amended to provide a "2-Year Temporary Certificate of Registration" to persons not yet licensed to practice medicine or osteopathy in the state. The Department may now:

(a) Issue a "Two-Year Temporary Certificate of Registration" to individuals who (1) hold a medical degree or equivalent (or have completed the work for and are eligible to receive this degree) from an approved U.S. or Canadian medical school and (2) have been accepted into an approved Illinois residency training program.

(b) Limit the permit's coverage to those areas where the holder is assigned as part of his educational program.

(c) Consider the permit valid for 24 months in the program where the holder is a participant.

The amendment provides that persons who are not Illinois residents need not promise to practice outside Illinois after their permanent license is obtained. It also states that the license "may not be extended or renewed unless the applicant receives a license to practice medicine in all its branches from the State in which he resides, and if a temporary certificate for a non-Illinois resident is thereafter extended it shall not extend beyond completion of the residency program."

DIVISION OF VOCATIONAL REHABILITATION

623 East Adams Street
Springfield, IL 62706
James S. Jeffers, *Director*

The Board of Vocational Rehabilitation is a statutory body, established to administer, through one division, the state program of vocational rehabilitation pursuant to the Federal Vocational Rehabilitation Act, as amended.

Medical Legal Information

(Prepared by ISMS Corporate Counsel)

The purpose of this article is to present the Illinois medical community with a general view of certain medical-legal principles and relationships which many physicians may encounter in the ordinary practice of their profession. Because this article is intended to provide information of a general nature only, specific problems should be discussed with one's individual attorney. While this presentation is not all-inclusive, it will afford an insight into the more common considerations. It should not be construed as presenting legal opinion, rather general considerations. Information is intended to be illustrative only and does not establish or imply a standard of care.

ISMS LEGAL SERVICES

The Illinois State Medical Society retains, on a continuing basis, a corporate counsel to whom the Society refers legal questions affecting the membership as a whole. ISMS also answers specific inquiries made by the component county medical societies when they are of general interest to the medical community. Although

the Illinois State Medical Society does not provide personal legal advice to individual members, the Society does believe the following information will help further each physician's awareness of certain basic legal principles and concepts vital to his practice.

THE PHYSICIAN-PATIENT RELATIONSHIP

Contractual Relationship

In most instances the physician-patient relationship is a voluntary, contractual one. Accordingly, physicians are required to accept only those patients they elect to treat. The professional services rendered on behalf of particular patients and the fees compensating the physician for those services are to be agreed between the physician and the patient. Whenever possible, the physician should discuss his fee with the patient in advance of treatment.

While a physician is free to determine who will be his patients, once the physician has undertaken the treatment of a particular patient, he is under a legal duty, subject to certain exceptions discussed below, to continue his attendance so long as the case requires attention. To disregard this duty may constitute negligence or malpractice on the part of the physician.

A physician may legally terminate his attendance of a particular case in several ways:

1. The contract between the physician and the patient expressly limits the scope of treatment;

2. The patient may discharge the physician;
3. The relationship may end by mutual consent;
4. The physician may legally terminate his services if the patient breaks the contract by failing to observe the medical directives of the physician.

In the event the patient fails to follow the physician's advice, the duties of the attending physician do not immediately terminate. Rather, the attending physician must provide the patient with sufficient, reasonable notice of his intention to withdraw so as to enable the patient to secure another physician. This notice should be in writing and briefly explain to the patient the reason for the intended termination. If the patient returns to the attending physician, and has been unable to procure other medical assistance, the attending physician should *not* refuse continued treatment until a replacement has been secured. Upon request, the physician should make copies of his records of the care he rendered to the patient available to a new physician selected by the patient.

HOSPITAL PATIENT RECORDS

Illinois law provides that hospitals in the state shall, upon the written demand of any discharged patient, permit that patient, the patient's physician or authorized at-

torney to examine and make copies of his hospital records. These disclosure provisions do *not* apply in the case of a psychiatrist-patient relationship.

NEGLIGENCE LIABILITY OF PHYSICIANS

Illinois law requires physicians and surgeons to exercise that degree of reasonable skill as is used in ordinary good practice. The failure to exercise such skill will result in liability if the patient is thereby injured.

In recent years, in part through the adoption of new laws, but primarily through court decisions, professional liability has been significantly expanded. A recent ruling of the Illinois Supreme Court, for example, extended liability in a certain circumstance for birth defects suffered by a child as a consequence of an injury its mother suffered eight years before the child was conceived. The Court reasoned that the defendant hospital and doctor should have known that the harm caused the mother could have resulted in injury to the child born many years later. This case establishes a "chain of accountability" which dramatically increases the doctor's liability and

underscores the fact that the problems associated with medical malpractice continue to jeopardize the delivery of quality medical care.

The physician is liable for his own negligent acts and the negligent acts of all employees subject to his control or supervision while acting within the scope of their employment. In the case of a partnership, he also may be liable for the negligent acts of his partners.

Today there is simply no existing alternative to carrying adequate liability insurance. However, insurance coverage is not a panacea for expanded liability. Each physician must undertake affirmative efforts to reduce the risks associated with the rendering of health care services.

The American Medical Association published a pamphlet entitled "Professional Liability and the Physician." Twenty guidelines for preventing malpractice actions are

set forth in that pamphlet:

1. The physician must care for every patient with scrupulous attention given to the requirements of good medical practice.

2. The physician must know and exercise his legal duty to the patient.

3. The physician must avoid destructive and unethical criticism of the work of other physicians.

4. The physician must keep records which clearly show what was done and when it was done, which clearly indicate that nothing was neglected, and which demonstrate that the care given met fully the standards demanded by the law. If any patient discontinues treatment before he should, or fails to follow instructions, the records should show it; a good method is to preserve a carbon copy of the physician's letter advising the patient against the unwise course.

5. A physician must avoid making any statement which constitutes, or might be construed as constituting, an admission of fault on his part. He should instruct employees to make no such statements.

6. The physician must exercise tact as well as professional ability in handling his patients, and should insist on a professional consultation if the patient is not doing well, if the patient is unhappy and complaining, or if the family's attitude indicates dissatisfaction.

7. The physician must refrain from over-optimistic prognoses.

8. The physician must advise his patients of any intended absences from practice and recommend, or make available, a qualified substitute. The patient must not be abandoned.

9. The physician must unflinchingly secure a consent, in writing, for medical and surgical procedures and for autopsy.

10. The physician must carefully select and supervise assistants and employees and take great care in delegating duties to them.

11. The physician should limit his practice to those fields which are well within his qualifications.

12. The physician must frequently check the condition of his equipment and make use of every available safety installation.

13. The physician should make every effort to reach an understanding with his patient in the matter of fees, preferably in advance of treatment

14. The physician must realize that it is dangerous to diagnose or prescribe by telephone.

15. The physician should not sterilize a patient solely for the patient's convenience, except after a reasonably complete explanation of the procedure and its risks and possible complications. He must also first obtain a signed consent from the patient and from the patient's spouse, if the patient is married. Eugenic sterilization should be performed only in conformity with the law of the state, if any. Sterilization for therapeutic purposes may be performed lawfully with the consent of the patient and preferably with the consent of the patient's spouse, if the patient is married.

16. Except in an actual emergency situation which makes it impossible to avoid doing so, a male physician should not examine a female patient unless an assistant or nurse, or a member of the patient's family is present.

17. The physician should exhaust all reasonable methods of securing a diagnosis before embarking upon a therapeutic course.

18. The physician should use conservative and less dangerous methods of diagnosis and treatment wherever possible, in preference to highly toxic agents or dangerous surgical procedures.

19. The physician should read the manufacturer's brochure accompanying a toxic agent to be used for diagnostic or therapeutic purposes and, in addition, should ascertain the customary dosage or usage in his area.

20. The physician should be aware of all the known toxic reactions to any drug he uses, together with the proper methods for treating such reactions.

In addition to these general guidelines to good medical practice, the physician should keep current and be in compliance with hospital regulations and standards enforced by governmental agencies, the Joint Commission on Accreditation of Hospitals, and the bylaws of his hospital and its medical staff. The physician has the responsibility to maintain good records of his care of his patients, to recommend consultation when the advice of a specialist is indicated, and to keep his patients informed of the progress of their care. The physician, as a member of an organized hospital medical staff, also has the duty to participate in, and submit to, peer review for purposes of monitoring his professional credentials and performance and for evaluating the quality and appropriateness of the patient care he delivers.

ILLINOIS CONTROLLED SUBSTANCES ACT

Under the Illinois Controlled Substances Act, physicians who prescribe or dispense various controlled substances are required to register with the Illinois Department of Regis-

tration and Education. Categories of drugs under which registration is required are almost identical to those established by the Federal DEA.

LIMITS ON LIABILITY—SPECIAL SITUATIONS

Under the "Good Samaritan" amendment to the Medical Practice Act, physicians who, in good faith provide emergency care without fee to a person, shall not, as a result of acts or omissions, except wilful or wanton misconduct, be liable for civil damages.

The Medical Practice Act further provides that any

physician, serving on any medical utilization committee, medical review committee, or peer review committee shall not be liable for civil damages as a result of his acts, or omissions, or decisions in connection with his duties on such committee, except those acts, omissions or decisions which involve wilful or wanton misconduct.

AUTOPSY

The *Illinois Revised Statutes* specifically detail the conditions under which a physician may perform an autopsy. Essentially, an autopsy may be performed provided:

1. The physician has a written authorization from the decedent to do so; or

2. The physician has a written authorization from a surviving relative who has the right to determine the method for disposing of the body or a next of kin or other person who has such right (a "surviving relative" means the spouse, an adult child, the parent, or an adult brother or sister of the decedent); or

3. The physician has a telegraphic or telephonic authorization from a surviving relative who has the right to determine the method for disposing of the body or a next of kin or other person who has such right. This last provision is conditioned, however, upon the requirement that the telegraphic or telephonic authorization is verified, in writing, by at least two persons who were present at the time and place the authorization was received.

Illinois law specifically provides that where two or more persons have equal right to determine the method for disposing of the body, the authorization of only one such person shall be necessary, unless, before the autopsy is performed, any others having such equal right shall object in writing or, if not physically present in the community where the autopsy is to be performed, by telephonic or telegraphic communication to the physician by whom the autopsy is to be performed.

While authorization may be given to a physician or hospital administrator or his duly authorized representative, only a physician shall perform the autopsy. The authorized personnel of a hospital or other qualified personnel selected by a physician may assist a physician per-

forming an autopsy.

The term "written authorization", provided for above, means any printed, typed or handwritten communication signed by the person granting the authorization.

It is important to emphasize that, in Illinois, the heirs and next of kin can bring an action for mutilation of the body of a decedent in those cases in which an autopsy is performed without authority or permission. In order to avoid the possibility of liability, autopsies should only be performed when ordered by the coroner or upon the appropriate written consent of the next of kin as specified above. (The coroner may order an autopsy directly against the wishes of the next of kin).

Since the controversy generated by the Karen Quinlan case, much has been written about the physician's role in determining death. Some states, Kansas and California, for example, have adopted special legislation in an attempt to "regulate" the legal and medical definitions of death and to provide so-called, "death with dignity" guarantees. To date, similar laws are not "on the books" in Illinois and, at present, the law of our state continues to provide that death occurs when in the judgment of the physician, there has been irreversible cessation of spontaneous vital functions (heart beat and respiration).

CONSENT OF MINORS TO MEDICAL TREATMENT

1. Situations Where Consent Need Not Be Obtained For Treatment of a Minor: Whenever a hospital or a physician renders emergency treatment or first aid (or a licensed dentist renders emergency dental treatment) to a minor, consent of the minor's parent or legal guardian need not be obtained if, in the sole opinion of the physician, dentist or hospital, the obtaining of consent is not reasonably feasible under the circumstances without causing a delay which could adversely affect the condition of such minor's health.

2. Parental Consent for Treatment of a Minor Child When Parent is Also a Minor: Illinois law provides that any parent, including a parent who is a minor, may give his or her consent to the performance upon his or her child of a medical or surgical procedure by a physician licensed to practice medicine and surgery or a dental procedure by a licensed dentist. The consent of such parent is not voidable because of his or her minority, and Illinois law specifically provides that this parent, who is a minor, is deemed to have the same legal capacity to act and shall have the same powers and obligations as has a person of legal age.

The consent to the performance of a medical or surgical procedure, by a physician licensed to practice medicine and surgery, which is executed by a married person who is a minor or by a pregnant woman who is a minor, is not voidable because of such minority and Illinois law further provides that for such purpose, such married person, who is a minor, or such pregnant woman, who is a minor, is deemed to have the same legal capacity to act and has the same powers and obligations as has a person who has attained majority (age 18 or older).

UNEMPLOYMENT COMPENSATION

The Illinois Unemployment Compensation law has recently been expanded so that it now includes coverage by physicians who employ only one person. This liability was discussed at some length in the "Practice Management" section of the July, 1973, issue of the *Illinois*

Medical Journal. If physicians have specific questions regarding the applicability of unemployment compensation to their employees, they should consult the Illinois Department of Labor, Division of Unemployment Compensation, or their attorney.

BLOOD LABELING

The Illinois Blood Labeling Act contains three requirements of particular importance to the medical profession:

1. No person may administer blood by transfusion in Illinois unless the container of such blood is labeled in conformity with regulations developed and specified by the Illinois Department of Public Health;

2. When blood is administered by transfusion in Illinois, the identification number of the unit of blood must be recorded in the patient's medical record and the label on the container of blood may not be removed before or during the administration of that blood by transfusion;

3. As of July 1, 1973, no blood (which has been initially

acquired by purchase) may be administered by transfusion in Illinois unless:

- a. The physician in charge of the treatment of the patient to whom the blood is to be administered has directed that such purchased blood be administered

to that patient; and

- b. The physician in charge of the treatment of the patient has specified in the patient's medical record his reason for such action.

IMMUNIZATION

In 1972, legislation was passed to eliminate the requirement of smallpox immunization and to add rubella to the list of diseases against which there must be immunization.

The 1973 session of the Illinois General Assembly, however, eliminated a listing of specific diseases against which

there must be immunization and transferred responsibility for determination of these to the Illinois Department of Public Health. Thus, the director will promulgate regulations, which may change from time to time, as to those diseases against which children will be immunized. This affects the School Code and the Communicable Disease Act.

MEDICAL CORPORATIONS

Until 1963, when the Illinois General Assembly passed the Medical Corporation Act, physicians were not able to avail themselves of the legal advantages of doing business as a corporation. A primary reason for forbidding the use of the corporate form for doctors was that the personal assets of the stockholders are generally beyond the reach of creditors, including persons who acquire a legal claim against the corporation after suffering injury resulting from the actions of the agents of the corporation. Because the public wished to insure itself of the best medical care, the law would not permit doctors to insulate themselves from personal malpractice liability by the use of a "corporate shield."

The corporate form does, however, present certain advantages, particularly in the area of taxation. There has never been a compelling reason to deny these benefits to doctors and other professionals.

Under the Illinois law, all the shareholders, officers and directors of a medical corporation must be licensed physicians. In the case of a professional services corporation also authorized under current Illinois law, the secretary of the corporation need not be a physician.

The corporation must register with the Illinois Department of Registration and Education under whose auspices it is permitted to operate, in addition to the requirements of filing with the office of the Secretary of State. This law explicitly denies physicians working within a corporation the right to insulate their personal assets from malpractice liability.

Tax consequences are the primary factors in determining the wisdom of incorporation. In an article written for the November, 1970, issue of the *Illinois Bar Journal* Linscott R. Hanson summarized the advantages of incorporation. Among the major advantages listed were:

1. Deductibility by employees of a portion of their sick pay.
2. Deductibility as a corporate business expense of the full cost of employee accident and health insurance.
3. Deductibility as a corporate business expense of medical payments in excess of insurance.

MDs EXCLUDED FROM 'CERTIFICATE OF NEED' CONTROLS

Plans to build, expand, move or sell a hospital, nursing home or surgicenter require approval of the State Health Planning Board.

A provision in the original legislation which would have brought physicians' offices and clinics under "certificate of need" regulation was withdrawn because of vigorous ISMS opposition.

This law covers construction or modification plans involving an expenditure of more than \$100,000, or a substantial change in services or bed capacity.

Under Public Law 93-641, local Health Services Agencies are to hold public hearings on all applications for construction or expansion of facilities before submitting a recommendation to the state Health Planning Board for final action.

The state agency is required to study: (1) area size; (2) population and growth potential; (3) number of exist-

4. Lower corporate tax rates for funds to be re-invested in the business.

5. Relatively easy adjustment of ownership percentages.

6. Avoidance of many probate problems upon the death of a practitioner and the avoidance of having to create a whole new business as when a partner dies.

7. Liability limitation, other than for malpractice, to the investment in the corporation thus reducing investors' risks.

8. Miscellaneous pension and profit-sharing tax advantages.

There are also some disadvantages or requirements associated with incorporation, as follows:

1. Since a corporation is a separate legal entity, there are certain minimal requirements necessary "to give life and credibility" to the corporate form (record keeping; governance; etc.). Simply declaring yourself a corporation is not enough; the law requires that you operate in accordance with laws governing corporate organizations. Occasionally problems can arise and the physician may incur costs of legal defense in his dealings with the Internal Revenue Service and other governmental bodies as when they challenge his activities carried out in the name of the corporation.

2. Corporations produce other unique costs as well, including additional social security taxes; corporate franchise taxes; capital stock and personal property taxes; increased state income taxes; state licensing fees; and other taxes and fees.

3. Corporations usually generate higher administrative and legal costs.

4. Corporations are subjected to many state and federal laws and regulations.

Certainly each practitioner, physician and partnership should consider the merits of incorporating. The purpose here has been to give a brief explanation so that each interested physician can receive a general over-view of his options. A tax specialist should, of course, be consulted to review the particulars of each business situation.

ing and planned facilities offering similar services; (4) utilization of existing facilities; (5) availability of alternative facilities and services; and, (6) availability of necessary personnel.

Undoubtedly, the role of health planning agencies will expand and the physician will feel the effects and influence of regulations promulgated by these organizations. While the private practice of medicine is as yet relatively "free" of the jurisdiction of these agencies, the decisions of the Board are already reaching out to limit the purchase of new equipment and the development of new services by hospitals and other institutions in which the doctor performs many of his professional services. It is reasonable to expect that with the current government emphases on cost containment in health care, the physician's practice can and will be affected. Therefore, it is in each physician's best interest to monitor these developments closely in the months and years ahead.

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Convention Handbook



INTERIM MEETING '77

Members of the House of Delegates

Delegates and Alternate Delegates to the Illinois State Medical Society
Downstate Delegates
Chicago Medical Society

Officers of County Medical Societies

ISMS Delegation to the American Medical Association

AMA Delegation Report

Schedule of Meetings

Committees of the House of Delegates

Resolutions

Members of the 1977

Interim Session

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	Earl Klaren	Richard Hawkins		Merle L. Otto	Albert Wm. Ray, Jr.
	Eugene Pitts	Homer Goldstein	WILLIAMSON	Robert J. Becker	John D. Walter
	Hugh Falls	Silverio Aguilar	WINNEBAGO (4)	Herbert V. Fine	Daniel Roth
		James Creath		Robert H. Behmer	R. Glenn Smith
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LEE	Donald Edwards	Kyu Jin Cho	STUDENTS	Harry W. Darland	Kazimieras Vascious
LIVINGSTON	Karl Deterding	John Purnell	HOUSESTAFF	Victor Jay	Tony Smith
				David Hopp	
				Paul Stromborg	

Chicago Medical Society

Delegates

Ackley, William O.
 Andelman, Samuel L.
 Blankshain, Richard
 Brislen, Andrew J.
 Brown, Finley W. Jr.
 Budrys, Stanley
 Burdick, Allison L., Sr.
 Burdick, Allison L., Jr.
 Burkhead, Howard C.
 Chamberlain, Danford O.
 Ciskoski, Roland J.
 Cohen, Meyer B.

Costanzo, Vincent A.
 Cross, Roland R.
 Des Rosiers, Raymond J.
 Dragisic, Branislav M.
 Falloon, Edwin L.
 Filipowicz, Roman I.
 Fischer, Arthur R.
 FitzGibbons, James P.
 Flaherty, Bernard P.
 Frankel, Jerome J.
 Freda, Vincent C.

Freidheim, Jere
 Friedell, Morris T.
 Friefeld, Nathan
 Gertz, George
 Guerrero, Severo K., Jr.
 Hamilton, Robert C.
 Hamilton, Samuel
 Harrod, John P., Jr.
 Hesselstine, H. Close
 Hinkamp, Joseph F.
 Horton, Loren B.

Hrejsa, Allen C.
 Hussey, Frank L., Sr.
 Hutchison, William A.
 Hyde, John S.
 Jirka, Frank J., Jr.
 Joslyn, A. Everett, Jr.
 Kaz, Alex H.
 Kirschenbaum, M. Barry
 Klinger, Alfred D.
 Kowal, Roland A.
 Kozak, John A.

Kunis, Arthur
 Kwinn, Frank C.
 Lagorio, George L.
 Lasky, Harold J.
 Lobraico, Rocco V., Jr.
 Lounsbury, B. Franklin
 Lukaszewski, Edwin J.
 MacNerland, Robert H.
 Marcus, Anna A.
 Markoutsas, George C.
 Marshall, William

Alternate Delegates

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 Andersen, James H.
 Ashley, William F.
 Banich, Francis E.
 Banuchi, Fedor F.
 Beck, Charles A.
 Berg, Max
 Bild, Sidney
 Borden, Nicholas J.
 Borelli, Nelson
 Bragman, Robert D.
 Burke, Edward A.

Byrne, Mitchel P.
 Cermak, Miles
 Chaljub, Najib
 Christensen, Eldis M.
 Clemis, Jack D.
 Cohen, Gerald
 Colbert, Maurice
 Coleman, John M.
 Constantaras, Alexander
 Czeisler, Tibor
 De La Mata, Augustin

De Rose, William F.
 De Trana, Frank A.
 Diaz, Alfonso
 Diffenbaugh, Willis G.
 Dolehide, Robert A.
 Drugs, Theodore G.
 Farah, George S.
 Fish, William
 Ford, James W.
 Fredrick, Earl E.
 Gaertner, Gene M.

Gau, Frederick
 Gnade, Gerard R.
 Goldstein, Henry A.
 Graham, James F.
 Green Martin W.
 Gross, Alvin
 Handler, Jerome L.
 Heller, Philip H.
 Hemwall, Gustav A.
 Hudec, Ronald L.
 Hussey, Frank L., Jr.

Jacobs, W. Francis
 John, Thomas
 Johnson, Theodore
 Jones, Richard
 Juhasz, John C.
 Kalsch, Harry E.
 Kass, Harold M.
 Khan, Abdul Haye
 Kobak, Mathew W.
 Krolkowski, John R.
 Lawrence, Arthur G.

Delegates

McCartney, Charles P.
 Mehlinger, Kermit T.
 Meisenheimer, Martin P.
 Moles, Joseph B.
 Muehrcke, Robert C.
 Murphy, Daniel J.
 Murray, Meredith B.
 Mustell, Robert R.
 Nagel, Frank E.
 Nemecek, Raymond W.
 Neskodny, J. F.
 Nicholas, Everett E.

Norberg, Clarence A.
 O'Brien, James C.
 O'Donnell, John W.
 Okner, Henry B.
 Palumbo, Carl F.
 Patlak, Erwin M.
 Perritt, Richard A.
 Peterson, Arthur R.
 Petty, David T.
 Quinlan, Donald
 Razim, Edward A.

Reeder, Clifton L.
 Rice, C. Malcolm Jr.
 Rothstein, David A.
 Ruiz, Gonzalo
 Ruzich, Stanley
 Sarley, Vincent C.
 Seed, Randolph W.
 Shapiro, Maynard I.
 Shobris, Martin
 Smith, C. Otis
 Smith, William

Soboroff, Burton J.
 Sofield, Harold
 Solon, Earl U.
 Sperling, Richard L.
 Staley, Warren H.
 Suckow, Earl N.
 Tansey, William J.
 Thompson, J. Robert
 Thomson, Andrew
 Tope, John W.
 Tovar, Jorge

Treister, Michael R.
 Turner, George C.
 Tworoger, Fred A.
 Walkowiak, Lydia
 Waller, Jesse E.
 Weigel, Charles J.
 Weingarten, Charles Z.
 Williams, Jack
 Xydakis, Stephanos A.
 Yanez, Frank
 Yatvin, Harold

Alternate Delegates

Lipsich, Michael
 McCabe, Mary Joan
 Mella, Luis
 Mikhail, Kamel A.
 Munoz, Maria
 Murphy, Thomas E.
 Nainis, William S.
 Naunton, Ralph
 Nikurs, Lydia
 Nowak, Frank J.
 Odiaga-Garcia, Ignacio
 Olivar, Adriano S.

Olivieri, Ernest P.
 Oselka, Adam
 Ostrowski, Fabian
 Panayotou, Irene
 Pantone, Anton M.
 Parisi, Frank
 Paull, Murry M.
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 Pill, Michael
 Plotis, Peter
 Pochyly, Donald

Poma, Pedro A.
 Prombo, Marjorie P.
 Pruc, Jeremias N.
 Rodriguez, Douglas D.
 Romanus, Raymond J.
 Rowlette, Raymond S.
 Roy, Shirley
 Ruane, Michael
 Saltiel, Isaac
 Saulys, Vacys
 Saxena, Virendra

Schifano, Joseph
 Schimel, Samuel J.
 Scruggs, Charles
 Sedlak, Frank C.
 Seskind, Coleman R.
 Siedlinski, John E.
 Sinaiko, Edwin S.
 Singh, Nerissa P.
 Spinka, Harold
 Springer, Harry A.
 Strohl, Lee H.

Stromberg, William B., Jr.
 Sugar, Sam J.
 Talso, Peter
 Tatoes, Constantine J.
 Ungar, Jacob
 Urban, Conrad J.
 Valadka, Bronius
 Wehrmacher, William H.
 Wolkonsky, Peter
 Yanong, Pio U.
 Zitik, Russell W.

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1977

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No Organized County Society

Johnson
Marshall
Menard
Putnam

Joint County Societies

Cass-Brown	Jersey-Calhoun
Coles-Cumberland	Morgan-Scott
Henry-Stark	Saline-Pope-Hardin
Jefferson-Hamilton	Will-Grundy

For further information about the convention or hotel reservation arrangements, please contact ISMS headquarters, 55 E. Monroe, Suite 3510, Chicago, 60603 (312) 782-1654.

ISMS DELEGATION TO THE AMA

Delegates

To Serve from Jan. 1, 1976 to Dec. 31, 1977
(Elected April 5, 1975)

Herschel Browns, Chicago¹
Howard C. Burkhead, Evanston
Jack Gibbs, Canton
Theodore Grevas, Rock Island
Morgan M. Meyer, Lombard
Edward A. Piszczek, Chicago
Fred A. Tworoger, Chicago

To Serve from Jan. 1, 1977 to Dec. 31, 1978
(Elected April 28, 1976)

Allison L. Burdick, Jr., Chicago
Alfred J. Faber, Chicago
David S. Fox, Chicago
Lawrence L. Hirsch, Chicago
Joseph R. O'Donnell, Glen Ellyn
John J. Ring, Mundelein
Charles K. Wells, Mt. Vernon

To Serve from Jan. 1, 1978 to Dec. 31, 1979
(Elected April 27, 1977)

Herschel Browns, Chicago
Howard C. Burkhead, Evanston
Jack Gibbs, Canton
Theodore Grevas, Rock Island
Morgan M. Meyer, Lombard
Joseph Skom, Chicago
Fred A. Tworoger, Chicago

Honorary Delegates

Walter C. Bornemeier, Saratoga, Cal.
Edwin S. Hamilton, Kankakee
Frank J. Jirka, Jr., River Forest
Burtis E. Montgomery, Harrisburg

Delegation Chairman: Jack L. Gibbs; Secretary: Herschel Browns

Alternate Delegates

To Serve from Jan. 1, 1976 to Dec. 31, 1977
(Elected April 5, 1975)

Robert R. Hartman, Jacksonville²
Eugene P. Johnson, Casey³
Lee Johnson, Litchfield⁴
Joseph B. Moles, Oak Park⁵
Maynard I. Shapiro, Chicago⁶
Glen Tomlinson, Lincoln
George T. Wilkins, Granite City

To Serve from Jan. 1, 1977 to Dec. 31, 1978
(Elected April 28, 1976)

Audley F. Connor, Chicago⁷
Henrietta Herbolsheimer, Chicago
Robert P. Johnson, Springfield

Fredric D. Lake, Evanston
Eugene T. Leonard, Rockford
Charles Schlageter, Chicago⁸
Andrew Thompson, Jr., Evanston⁹

To Serve from Jan. 1, 1978 to Dec. 31, 1979
(Elected April 27, 1977)

Robert R. Hartman, Jacksonville
Eugene P. Johnson, Casey
Maynard I. Shapiro, Chicago
Andrew Thomson, Jr., Evanston
Glen E. Tomlinson, Lincoln
Cyril C. Wiggishoff, Chicago
George T. Wilkins, Granite City

¹Elected to 14th delegate position

²Elected to fill unexpired term of Joseph R. O'Donnell

³Elected to fill 14th alternate delegate position

⁴Elected to fill unexpired term of J. M. Ingalls

⁵Elected to fill unexpired term of Herschel Browns

⁶Elected to fill unexpired term of George Shropshire

⁷Elected to fill unexpired term of Joseph H. Skom

⁸Deceased

⁹Elected to fill unexpired term of Allison Burdick, Jr.

Illinois Delegation to the American Medical Association

Report to the Membership

The Illinois Delegation to the American Medical Association submitted five resolutions for consideration by the AMA House of Delegates in June. Following is the action taken on these resolutions:

Resolution 87—Generic Labeling for Drugs Crossing International Borders

This resolution asked the AMA to encourage international agreements to require the generic and brand names as well as the chemical composition to be on the labeling of drugs transported by patients crossing international borders, develop a document for verifying chemical, generic and brand names of drugs marketed in the various countries and urge "Physician's Desk Reference" to include the synonyms for the most commonly used international drugs in future editions. Although the reference committee considered implementation of this resolution to be impractical and stated that much of the information about drugs was already in AMA hands and needed only to be published for the availability of members, the House referred the matter to the Board of Trustees for further investigation.

Resolution 88—Treatment of Persons with Hearing Disorders

This resolution was amended and adopted as follows:

Resolved, That it be the policy of the American Medical Association that physicians licensed to practice medicine in all of its branches remain the primary entry point for the medical care of patients with hearing impairment; and be it further

Resolved, That the AMA go on record as being in favor of continued physician supervision and treatment of hearing, speech and equilibratory disorders.

Resolution 89—Peer Review of Non-Members

This resolution asked the AMA to encourage medical societies to conduct peer review on the practice of all physicians, not just those who belong to the medical society. It was referred to the Board of Trustees for further study and report.

Resolution 90—Medicare Part B Payments and Physician Profiles

This resolution asked the AMA to seek immediate and far-reaching discussions with appropriate members of Congress and the Department of Health, Education and Welfare to eliminate as an inequitable form of payment the use of outdated fee profiles. It was considered with two other resolutions and a report of the Council on Medical Service. The reference committee recommended that the council report be amended and adopted in lieu of the three resolutions. Various amendments were offered from the floor before the entire matter, including all proposed amendments, was referred to the Board of Trustees and Council on Legislation.

Resolution 91—Ethical Standard for Definition of Expert Medical Witness

This resolution was considered with a similar resolution and the following substitute was adopted:

Resolved, That the American Medical Association express concern about physicians who testify in medical malpractice cases without having a current basic educational and professional knowledge as a general foundation for their testimony; and be it further

Resolved, That the AMA is concerned about the impact of testimony of those physicians who make it part of their occupation to function frequently as hired expert witnesses and color their testimony accordingly; and be it further

Resolved, That the AMA condemn those physicians who interfere with the proper administration of justice by giving false or misleading testimony or misrepresenting their qualifications; and be it further

Resolved, That the AMA urge the courts to refuse to admit as expert testimony the testimony of those physicians who do not have clear cut qualifications as recognized by their peers; and be it further

Resolved, That the AMA urge state and county medical societies to take appropriate legal action or initiate disciplinary action before the appropriate medical licensure board when physicians testify without having a current basic educational and professional knowledge, testify falsely, or give deliberately misleading testimony; and be it further

Resolved, That the AMA encourage state medical associations to seek a legislative definition of acceptable expert witnesses.

In addition to these Illinois delegation resolutions, the House considered and referred to the Council on Medical Education a resolution introduced by Dr. Morgan Meyer urging the AMA to support Title VI of Public Law 94-484 concerning alien physicians, and to encourage better utilization of the Fifth Pathway as a means of helping qualified American citizens who are studying medicine in foreign schools to return to the United States to practice medicine.

Two Illinois physicians won election to AMA councils. Dr. John Ring was elected to the Council on Medical Service and Dr. James DeBord elected to the resident position on the Council on Scientific Affairs.

Members of the delegation serving on House committees were: Dr. Alfred Faber, Chairman of

Reference Committee E; Dr. Jack Gibbs, Committee D, and Dr. David S. Fox, Committee G. Dr. E. T. Leonard served as a teller.

In an attempt to help improve AMA procedures, the Illinois Delegation will develop resolutions to:

(a) Provide a better method of selecting reference committee chairmen.

(b) Insist that reference committee reports be written by committee rather than staff and legal counsel.

(c) Require the AMA—and particularly its Washington office—to utilize the expertise that exists at the state level through the officers and staff of constituent organizations.

Jack Gibbs, M.D.
Chairman

Herschel Browns, M.D.
Secretary

ISMS Travel Program

The following ISMS sponsored travel programs have been scheduled for 1978:

January 3-12—*West Indies Air/Sea Cruise* (Leeward & Windward Islands)

March 2-10—*South America—Quito & Lima* (Optional tour of Galapagos Islands)

May 5-19—*Egypt-Greek Isles* (6 days Cairo—6 days Greek Isles Cruise).

July 6-20—*Scandinavia—*(Stockholm, Helsinki, & Copenhagen—Optional tour to Leningrad)

Sept. 5-19—*Imperial Europe* (Vienna, Budapest & Dubrovnik)

Nov. 1-14—*Eastern Mediterranean Air/Sea Cruise* (Greek Isles, Turkey, Egypt, & Israel)

Descriptive brochures will be mailed five months in advance. Reservations cannot be accepted without the official form printed in these brochures. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. *Promotional expenses connected with these programs are paid for by the tour operator.* For further information, contact ISMS headquarters.

ILLINOIS STATE MEDICAL SOCIETY
SCHEDULE OF MEETINGS
INTERIM HOUSE OF DELEGATES

November 11-13, 1977

Sheraton-St. Louis Hotel
910 North Seventh Street
St. Louis, Missouri

Friday, November 11, 1977

9:30 a.m.	Board of Trustees Meeting
12:00 noon	Board of Trustees Luncheon
5:30 p.m.	Board of Trustees Reception and Dinner
7:30 p.m.	Board of Trustees Meeting

Saturday, November 12, 1977

7:30 a.m.	Board of Trustees Breakfast
9:30 a.m.	ISMIE Board of Governors Meeting
9:30 a.m.	Delegates Registration Opens
10:00 a.m.	Meeting of Reference Committee Personnel
11:00 a.m.	Delegates Check-in with Credentials Committee
12:00 noon	House of Delegates Meeting
1:30 p.m.	District Caucuses
2:30 p.m.	Reference Committee Meetings
5:00 p.m.	University of Illinois Alumni Reception

Sunday, November 13, 1977

7:30 a.m.	Board of Trustees Breakfast
9:00 a.m.	Delegates Check-in with Credentials Committee
9:30 a.m.	House of Delegates Meeting

Committees of the House of Delegates

1977 Interim Meeting

COMMITTEE ON RULES & ORDER OF BUSINESS

Robert Hamilton, *Chairman* (CMS)

Vincent A. Costanzo (CMS) Anna Marcus (CMS)
Herbert V. Fine (DS) Eugene Pitts (DS)
George C. Markoutsas (CMS), *Standby*

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the session of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

COMMITTEE ON CREDENTIALS

B. Franklin Lounsbury, *Co-Chairman* (CMS)

William C. Perkins, *Co-Chairman* (DS)
George Gertz (CMS) Walter P. Plassman (DS)
R. K. Swedlund (DS)

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

TELLERS AND SERGEANTS AT ARMS

D. H. Rames, *Chief Teller* (DS)

William O. Ackley (CMS) M. T. Salaymeh (DS)
Clarence A. Norberg (CMS)
Carl F. Palumbo (CMS) *Standby*

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

Donald Quinlan, *Chairman* (CMS)

Edward K. DuVivier (DS) Rocco Lobraico (CMS)
C. B. Lara (DS) William Tansey (CMS)
Martin Shobris (CMS) *Standby*

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws.

REFERENCE COMMITTEE A

Robert A. Behmer, *Chairman* (DS)

Branislav Dragisic (CMS) William B. Frymark (DS)
Jere Freidheim (CMS) Robert Prentice (DS)
Bernard Flaherty (CMS) *Standby*
Richard M. Terry (DS) *Standby*

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions relating to officers, administration, finances, budgets, education and membership services.

REFERENCE COMMITTEE B

Earl Suckow, *Chairman* (CMS)

Roland Cross (CMS) John F. Hubbard (DS)
E. J. Fesco (DS) Frank C. Kwin (CMS)
Allen C. Hrejsa (CMS) *Standby*
M. W. Elliott (DS) *Standby*

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions and reports relating to government health programs.

REFERENCE COMMITTEE C

O. W. Pfisterer, *Chairman* (DS)

Charles Eddingfield (DS) Gonzalo Ruiz (CMS)
Roland Koval (CMS) George Shimkus (DS)
Don E. Hinderliter (DS) *Standby*
Joseph Hinkamp (CMS) *Standby*

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions relating to medical service and scientific matters.

REFERENCE COMMITTEE D

Maynard Shapiro, *Chairman* (CMS)

E. C. Bone (DS) Edward Razim (CMS)
Merle Otto (DS) J. Robert Thompson (CMS)
Lee Johnson (DS) *Standby*
Meyer Cohen (CMS) *Standby*

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions relating to governmental affairs and medical-legal matters.

REFERENCE COMMITTEE E

David Helberg, *Chairman* (DS)

William Marshall (CMS) Paul Lorenz (DS)
Harold Kolb (CMS) David Rothstein (CMS)
Richard Arnell (DS) *Standby*
John Kozak (CMS) *Standby*

This committee shall consider and submit its recommendations to the House of Delegates upon resolutions relating to miscellaneous business.

Resolutions

Resolution 77N-1

Introduced by: James Laidlaw, M.D., for the
Board of Trustees

Subject: Amendment to Section 11 of Chapter X
Referred to: Reference Committee on Amendments to
Constitution and Bylaws

WHEREAS, The Committee on Constitution and Bylaws has recommended that membership reinstatement provisions in the bylaws are in need of clarification; therefore be it

RESOLVED, That Section 11 of Chapter X be amended as follows:

A member is in good standing, unless otherwise disqualified, whose dues are received by ISMS on or before March 31 of the current year. Delinquent members shall be notified that in consequence of non-payment of dues, their membership is delinquent. If dues or assessments remain unpaid as of April 30 of the current year, the member shall be considered delinquent and membership shall be dropped automatically. The member may be reinstated by paying all delinquent dues, provided, in the interim, he has not been guilty of conduct prejudicial to membership; but if two or more years have elapsed since he was a member in good standing, he must, in addition, make application as a new member. *In the event that a physician is dropped for delinquency, he is obligated, before being reinstated, to pay the half year's dues which he owed before his membership was terminated.*

A member in good standing who resigns voluntarily by December 31 of any year may be reinstated, but if two or more years have elapsed, he must apply as a new member.

Resolution 77N-2

Introduced by: Joseph R. O'Donnell, M.D.
Subject: Confidentiality
Referred to: Reference Committee D

WHEREAS, PSRO's will collect or generate data of such high quality and consistency; and

WHEREAS, PSRO's potentially could be regarded as a source of information for government agencies, researchers and other unspecified organizations; and

WHEREAS, The confidentiality of patients and practitioners of medicine must always be of concern; therefore be it

RESOLVED, That ISMS and AMA should encourage legislation, such as Congressman Crane's bill, HR 15043 introduced in August, 1976, so that Congress would be provided with oversight of all regulations relating to utilization review and PSRO review in order that confidentiality of records be maintained for all patients preventing access to such records by the federal bureaucracy.

Resolution 77N-3

Introduced by: Joseph R. O'Donnell, M.D.
Subject: Public Relations Program Regarding Aetna Earnings

Referred to: Reference Committee C

WHEREAS, Aetna Life Insurance Company has seen fit to advertise publicly the fact that it has been able to "reduce MD's fees by an average of \$50 in one-half million claims" (*Newsweek* 8/8/77); and

WHEREAS, Simultaneously, Aetna Life Insurance Company issued an annual financial report stating it has achieved a 119% increase in earnings (from \$86 million to \$188.4 million) in the first half of 1977 (*Wall Street Journal* 8/1/77); therefore be it

RESOLVED, That the diametrically opposed philosophies—earnings of MDs vs. earnings of Aetna Life Insurance Company—be widely publicized by the medical profession as an example of self-seeking personal gain on the part of the insurance company; and be it further

RESOLVED, That the ISMS conduct a "counter" public relations campaign against Aetna's practice of reducing MD's fees to increase its own earnings; and be it further

RESOLVED, That the Illinois Delegation to the American Medical Association be instructed to introduce a similar resolution in the AMA House of Delegates.

Resolution 77N-4

Introduced by: Thomas W. Stach, M.D.
Subject: Encouraging Use of CPT-4
Referred to: Reference Committee B

WHEREAS, It is in the mutual interest of patients, third parties and physicians that a common terminology be utilized for describing and reimbursing physician procedures; therefore be it

RESOLVED, That ISMS introduce the following

at the December, 1977, AMA House of Delegates:

RESOLVED, That AMA vigorously undertake those activities necessary, including but not limited to legislation, to insure that Current Procedural Terminology Edition IV is recognized and accepted by all Medicare intermediaries and a report furnished the House at six-month intervals until accomplished.

Resolution 77N-5

Introduced by: Thomas W. Stach, M.D.
Subject: Recission of 1971 Base Year Data
Referred to: Reference Committee B

WHEREAS, Various federal regulations and PL 92-603 have violated the original intent of Medicare to recognize physicians' usual, customary and reasonable fees; therefore be it

RESOLVED, That the Illinois Delegation to the AMA introduce the following resolution in the AMA House of Delegates:

RESOLVED, That the AMA, through legislative or judicial means, obtain recission of the use of 1971 base year data, or the use of any other base year data on a permanent basis, for any Medicare calculations; and be it further

RESOLVED, That the AMA, through legislative or judicial means obtain abolishment of the use of an economic index applied to Medicare reimbursement calculations; and be it further

RESOLVED, That program reports on these efforts be furnished the House of Delegates until accomplished.

Resolution 77N-6

Introduced by: Morgan M. Meyer, M.D.
Subject: Rotating Internships
Referred to: Reference Committee A

WHEREAS, Several specialty groups, including Psychiatry, Pathology, Anesthesiology, Radiology and Nuclear Medicine, have found straight internships to be undesirable during the recent few years that rotating internships have been eliminated; and

WHEREAS, The AMA Council on Medical Education is reconsidering its original position on the desirability of the rotating-mixed internships; and

WHEREAS, The pyramid of training for the various surgical sub-specialties, as well as the above specialties, is requiring more and more space in the various departments of Internal Medicine; and

WHEREAS, There are many community hospitals capable of providing for rotating internship training; therefore be it

RESOLVED, That the Illinois State Medical Society introduce legislation requiring rotating internships

for licensure in the State of Illinois; and be it further

RESOLVED, That the State Society's AMA delegation urge the AMA to encourage a return to rotating internships throughout the country.

Resolution 77N-7

Introduced by: Joseph R. O'Donnell, M.D.
Subject: Aetna

Referred to: Reference Committee C

WHEREAS, Much of the cost of medical services is covered by third-party carriers under the guise of total insurance coverage; and

WHEREAS, Aetna Insurance Company uses unequal comparisons as to what prevailing charges are for medical services rendered in different areas of the country (Aetna-*Newsweek* 8/8/77); and

WHEREAS, This type of advertising is both misleading and not factual; therefore be it

RESOLVED, That ISMS develop an intensive public relations program to counteract misleading advertising of third-party carriers using unequal comparisons as to what prevailing charges are for medical services rendered in different areas of the country; and be it further

RESOLVED, That the Illinois Delegation to the American Medical Association be directed to introduce a resolution in the AMA House of Delegates calling for establishment of liaison committees between third-party carriers and organized medicine on all levels of activities (local, state and national) to correct misinformation published as advertising by the carriers.

Resolution 77N-8

Introduced by: Thomas W. Stach, M.D.
Subject: Public Relations Program
Referred to: Reference Committee C

WHEREAS, The need for improved public attitudes toward the medical profession is evident; and

WHEREAS, Groups hostile to the profession indulge in distorted public messages; therefore be it

RESOLVED, That the Illinois Delegation to the American Medical Association introduce a resolution in the AMA House of Delegates mandating a vigorous public relations campaign to maintain the medical profession's image of respect and integrity and to challenge the distorted public messages—including distorted information about medical costs—issued by groups hostile to medicine.

Doctor's News

STATE AIDS PHYSICIAN RECRUITMENT—Legislation to fund grants for medical students who choose to serve their residencies in areas suffering physician shortages was signed into law last month. The program will be administered through the Department of Public Health and the grants will take the form of scholarships requiring three years' service in the designated area after residency completion.

PHYSICIAN REFERRAL—The Chicago Medical Society has expanded its referral service to include recommendations for physicians to give second opinions on elective or non-emergency surgery. In announcing the expansion, Dr. Morris Friedell, CMS President, noted that while several insurance carriers do cover second opinions, the responsibility for payment does rest with the patient. The program will begin in January.

CME NEWSLETTER RESUMED—The American Medical Association *Continuing Medical Education Newsletter*, discontinued in 1974 due to budget restrictions, has been reborn. Persons interested in receiving it should contact Marvin E. Johnson, M.D., Editor, at the AMA, 535 N. Dearborn Street, Chicago, IL 60610.

VISITING FELLOWSHIPS AVAILABLE—The SIU School of Medicine has announced that all Illinois doctors are eligible for visiting fellowships for individualized clinical experience. Under the program, the physician applicant selects a specific topic and the project is tailored to his interests. Duration may vary from one day to three months. For further information, contact William S. VanBergen, M.D., Clinical Assistant Professor, Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708.

ALLERGIC MOTHERS—A group of researchers at Northwestern University Medical School have found that pregnant women who suffer from asthma or hay fever may continue immunotherapy without risking harm to the fetus. They have found that particular medications which were taken by 71 allergic women in the study, produced no more uterine hemorrhages, stillbirths or congenital malformations than were experienced in the 88-person control group, who took no medications.

CME TV—The American Medical Association plans to market "CME Video Clinics," a series of taped continuing medical education packages including syllabi, tests and instructions for home or hospital use. Each meets the criteria for Category I credit in the Physician's Recognition Award program. The tapes, which will cover a variety of clinical interests, are developed by the AMA Council on Continuing Physician Education and a cross-section of leading medical school faculty.

PHYSICIANS IN THE NEWS—A Northbrook cardiologist, **William A. Appelbaum, M.D.**, was recently appointed associate director of the intensive care unit at Martha Washington Hospital in Chicago. Doctor Appelbaum is a staff member at Weiss Memorial Hospital, Skokie Valley Hospital and also Mt. Sinai Hospital. He formerly practiced at the Great Lakes Naval Regional Medical Center. . . . **Robert G. Addison, M.D.**, Chicago, director of the Low Back and Pain Clinic at the Rehabilitation Institute of Chicago, has been elected Chief of Staff by the Institute's board of directors and medical staff. . . . The Illinois Chapter of the American Academy of Pediatrics has announced that **Eugene Diamond, M.D.** began a three-year term as their president in July, 1977. He is chairman of the Department of Pediatrics at St. Francis Hospital in Blue Island. A resident of Palos Park, Dr. Diamond is on the staff of Palos Hospital and Loyola University Hospital.

NO SMOKING AWARD—The Illinois Interagency Council on Smoking and Disease recently presented an award to Doctor David Fox, ISMS president-elect, in recognition of Resolution 74A-2, passed by the 1977 House of Delegates. The resolution condemned the sale of cigarettes in hospitals and called upon ISMS members to work actively to ban smoking in hospitals.

PLASTIC SURGERY is the subject of an interesting article included in this year's *1978 Yearbook of Science and the Future* published by the Encyclopaedia Britannica, Inc., and available in local bookstores. The article, written by Peter McKinney, M.D., associate professor of clinical surgery at Northwestern University Medical School, considers the history of plastic surgery, dating to 600 B.C., and its growth through the twentieth century. McKinney points out the specialty is not primarily cosmetic, but rather one whose objectives center on pathological conditions, traumatic injury and genetic disfigurements.

RESEARCH PRIZES OFFERED—The Institute of Medicine of Chicago has announced that two awards for study completed in 1977 will be offered to physicians who completed medical school between July 1, 1971 and July 1, 1977. The Joseph A. Capps Price recognizes meritorious research in medicine or in its specialties. The Dr. and Mrs. Elven J. Berkheiser Price encourages original work in the field of orthopaedic surgery. Both prizes are given for work carried out in the metropolitan Chicago area, and each amounts to \$750.

THE ILLINOIS LUNG ASSOCIATION has prepared informative material on both the effects of tobacco on the smoker and the harm of second-hand smoke on all people for use in office reception areas or other appropriate places. Physicians who would like copies of these materials at no charge should contact the Illinois Lung Association, 725 S. 26th St., P.O. Box 2576, Springfield 62708, or phone (217) 528-3441.

WHOOPS—"Operative Mortality of Coronary Bypass Surgery" was the title of an article by Doctors Eugene H. Schmitt and Edward H. Sharp carried in the August *IMJ*. Shortly after publication, staff learned that the authors' photos had been inadvertently transposed. The case of mistaken identity can be solved by noting that the photo of Doctor Sharp is really Doctor Schmitt. And vice versa. We apologize.



"What's Next"

When I'm asked about a young patient's prognosis, I usually tell the parents that "we have some problems, but I believe we can overcome them." My reply is similar when queried about the outlook for our profession.

A football game would be dull without opponents attempting to stop the ball carrier. Likewise, life would be dreary without obstacles to conquer. Those of us who have a true zest for life usually are motivated by the challenge of "what's next?"

For physicians, "what's next" is the challenge to quality health care presented by state and federal bureaucracies. The latest threat emanating from the banks of the Potomac is President Carter's push for fixed cost controls. I firmly believe that with the correct attitude we can surmount this and all other hurdles government places in our path. Our patients will be well-served by our efforts.

A handwritten signature in cursive script that reads "George Wilkins Jr." The signature is fluid and elegant, with a prominent "G" and "W".

George T. Wilkins, Jr., M.D.

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Obituaries

*Agulia, Fernando I., Chicago, died August 19 at the age of 75. Doctor Agulia was a 1929 graduate of the Loyola University Stritch School of Medicine.

*Greenley, David McLean, Boscobel, Wisconsin, formerly of Evanston, died August 17 at the age of 65.

*Greenberg, Harold A., Chicago, died August 17 at the age of 68. Doctor Greenberg was a 1933 graduate of the University of Minnesota.

*Kostalek, Mary E., Waukegan, died July 27 at the age of 59. Doctor Kostalek was a 1941 graduate of the University of Oregon Medical School.

*Marshall, William Allen, Fairbury, died July 29 at the age of 89. Doctor Marshall was a 1910 graduate of the University of Western Ontario.

*Smith, Herman, Chicago, died August 20 at the age of 84. Doctor Smith was a 1913 graduate of New York University.

Carr, Archie D., St. Louis, died August 1 at the age of 81. Doctor Carr was a 1920 graduate of Washington University School of Medicine.

Griesbach, Peter, McHenry County, died in late September of this year.

Horkavy, John, Chicago, died September 4 at the age of 69.

Pertt, Louis, Lincolnwood, died August 31 at the age of 64.

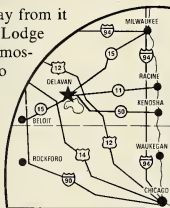
Teffner, Count, Chicago, died August 8, at the age of 91. Doctor Teffner was a 1915 graduate of Wiley College and Mehary Medical School.

*Indicates ISMS member.

•Indicates member of the ISMS Fifty Year Club.

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This week get away from it all! Lake Lawn Lodge has the restful atmosphere you need to unwind. Call Chicago (312) 372-6062 for reservations, or call or write us directly.



Abstracts of Board Actions

(Continued from page 243)

ISMS to Co-Sponsor or Endorse Several Symposia, Projects

In response to requests from various organizations, ISMS will:

- Co-sponsor the 20th Annual Fall Conference on Nutrition in Medicine, Oct. 7, 1977, and the Seventh Biennial Nutrition Symposium, April 19, 1978. Co-sponsorship of each involves a \$300 grant and printing services. Other co-sponsors will be asked to: (1) Submit reports and critiques of the programs so ISMS can make a decision concerning further involvement; and (2) Offer, whenever possible, medical topics.
- Co-sponsor an Illinois Cancer Council (ICC) symposium this winter provided ICC obtains accreditation and grants IMJ first publication rights to paper presented. As a co-sponsor, ISMS will not be under any direct financial obligation, but will publish promotional articles in IMJ and ACTION REPORT, print 300 brochures and provide ICC with labels for the ISMS membership. The session will focus on: (1) Smoldering leukemia; (2) Hairy cell leukemia; and (3) Acute leukemia developing after treatment of malignant lymphomas.
- Endorse an IDPH statewide hypertension project and cooperate in its implementation. The project is designed to coordinate policy, research and resources for hypertension control.
- Endorse—and encourage county society cooperation in—an IDPH immunization project designed to: identify locales with low immunization percentages among children; assist and encourage physicians to review patients' immunization records; and improve recognition of disease outbreaks and provide vaccines. ISMS endorsement also applies to IDPH efforts to obtain federal funding for the project.

Schedule Doctor's Job Fair

The fifth annual Doctor's Job Fair will be held Sunday, Dec. 4, at the Sheraton Oak Brook Hotel, Oak Brook. While the overall Physician Recruitment Program will remain unchanged, registration fees will be increased from \$75 to \$80 for communities, entitling them to participate in the Job Fair plus four IMJ ads and monthly mailings of names of available physicians. Communities that wish to participate in the Recruitment Program—but not the Job Fair—would be charged \$35.

Malpractice

ISMS will join with the Illinois Hospital Association to file an amicus curiae brief with the Illinois Supreme Court. The brief will be submitted in conjunction with a petition for rehearing of a malpractice case in which the court upheld the right of a child to sue for injuries allegedly suffered at birth, when events which apparently caused those injuries occurred before the child was conceived.

Appointments/Nominations

Dr. Lee Gladstone, Chicago, was appointed the ISMS representative to the IDPH Alcoholism Treatment Facility Licensure Advisory Board, replacing Dr. James West who resigned but will serve as an alternate.

The following physicians were nominated for appointment to a technical advisory council mandated under the Generic Prescribing Act passed by the legislature: Drs. Vincent Costanzo, Jr., and Norman Ehrlich, both of Chicago; Robert C. Muehrcke, Oak Park; Richard Suhs, Springfield; Frank Norbury, Jacksonville; and Dorothy Hubler, Casey. The main function of the council would be to assist in development of a positive formulary of bioequivalent drugs. The seven-member body would consist of two physicians, two pharmacists, two pharmacologists and one other prescriber with special knowledge of generic drugs.

National Legislation

The Society will inform AMA of its opposition to "compulsory, government-mandated national health insurance plans." The official notification is in response

to an AMA House of Delegates' directive to poll state medical societies for their views on the Association-sponsored NHI plan. ISMS also will urge all county societies to evaluate their position on NHI and communicate their opinion through delegates at the ISMS House of Delegates session in November.

In other action on national legislation, the Board voted to:

- Support the AMA position that physician extenders should: (1) Work under direct supervision of the performing physician who shall be responsible for their actions; and (2) Work on a one-to-one basis with physicians. ISMS will emphasize that registration and regulation of extenders should be the sole authority of the individual states. A special subcommittee of the ISMS Council on Education and Manpower will be appointed to study the physician extender issue.
- Support AMA opposition to Medicare/Medicaid fraud and abuse legislation because the proposals involve PSROs and thus will weaken the educational objective of the review organizations. ISMS will appoint a committee to explore the feasibility of establishing a mechanism to identify fraudulent Medicare/Medicaid activities—while protecting the confidentiality of patient records—through organized medicine at the state level.
- Inform AMA and the Illinois Congressional delegation that it opposes any legislation subjecting physicians' offices to potential federal licensure or regulation for laboratory work done on a physician's own patients. Results of an IDPH study on physician lab proficiency testing will be reviewed to determine the need for future legislation.
- Decline a request by the Louisiana State Medical Society for a donation to aid its development of literature opposing national health insurance proposals.
- Urge county medical societies to immediately implement the campaign—voted by the House of Delegates—designed to "alert the public to the drift toward a national health service." A packet of background information developed by ISMS to help county societies implement the campaign will be submitted to the AMA Board of Trustees for review before it is distributed to other state societies.

Medicaid

The Board took the following actions concerning Medicaid payment policies: (1) Directed legal counsel to prepare appropriate data and available options for potential legal action challenging IDPA's low and discriminatory payment policies; (2) Authorized a meeting with IDPA to explore alternative Medicaid payment methods.

ISMS will request AMA assistance in transposing IDPA computer tapes from CPT 2 to CPT 4. IDPA plans to use the CPT 4 code totally as part of its Medicaid Management Information System, replacing the so-called private code number currently used. IDPA requested ISMS assistance in changing the coding system.

Revisions in Policy Manual Bylaws

In accordance with House of Delegates' action, the Board approved policy statements on the following subjects for inclusion in the Policy Manual: health care costs, hospitals, legal definition of death, death with dignity, mental health, peer review, governmental health insurance programs, voluntary health insurance plans, expert witnesses, impartial medical testimony, hearing disorders, correct procedural terminology, physicians, financial policies and informing the membership.

The Board also: (1) Delayed publication of a policy statement concerning criteria to be observed if generic drug substitution is allowed pending action by the Governor on a bill passed by the General Assembly; and (2) Directed the Policy Committee to review the Policy Manual and recommend appropriate changes to the House of Delegates.

In addition, the Board: (1) Postponed action on a proposal to grant House of Delegates voting privileges to specialty society representatives until there has been experience with recently-granted "floor" privileges; (2) Referred to the Policy and Constitution and Bylaws Committees for further study the issue of peer

review of non-members, including the development of policy to distinguish between peer review and professional standards review; and (3) Approved a Bylaws change allowing members who voluntarily resign by Dec. 31 to later be reinstated without obligation for dues during the period of non-membership.

Physician Advertising

Due to a Supreme Court ruling on professional advertising, ISMS will review its position on physician advertising and develop appropriate guidelines. The guidelines will include the advertising policy of the Illinois Medical Journal.

Hospital Licensing Act Regulations

The Board approved several proposed additions to Hospital Licensing Act regulations dealing with physician's assistants and assistants at surgery.

Guidebook on Medical Staff Credentialing/Privileges

ISMS will cooperate with the Illinois Hospital Association in development of—but not co-sponsor or endorse—a manual outlining medical staff credentialing, delineation of privileges and re-appointment.

Peer Review Guidelines

The Board approved peer review guidelines—proposed by the State Medical Advisory Committee to Public Aid—to be used in peer review of physicians treating public aid recipients.

Triplicate Prescription Form

ISMS will continue to negotiate with the Dangerous Drugs Commission regarding appropriate listing of designated products requiring the triplicate form. An ISMS suit challenging the expanded list of designated products requiring the form currently is on continuance in Cook County Chancery Court.

Alcoholism

The Society will accept funds—through the Educational and Scientific Foundation—from the Illinois Division of Alcoholism for development of alcoholism treatment training materials. The printed and audio-visual materials would be used in conjunction with Scientific Speakers Bureau activities. In related actions, the Board voted to: (1) Endorse the University of Illinois' School of Public Health curriculum concerning therapy for impaired physicians. The program would complement efforts of the ISMS Panel for the Impaired Physician; and (2) Inform the Illinois Alcoholism and Drug Dependence Association that proposed criteria for certification of alcoholism counselors is unacceptable.

Student Business Session

The Board took the following action concerning the Student Business Session:

- Appointed William Ketcherside a student representative to the ISMS Council on Mental Health and Addiction.
- Authorized payment of travel expenses for: (1) One representative from each downstate medical school attending meetings of the SBS, Governing Council in Chicago; and (2) SBS chairman to attend the 1977 Interim House of Delegates session in St. Louis.
- Granted SBS permission to publish a newsletter (not more frequently than bi-monthly) with assistance of ISMS staff. Expenses were limited to \$2,000 annually.

Medicare Brochure

A brochure describing benefits and gaps of Medicare coverage will be offered at cost to members for distribution to patients. Availability of the pamphlet also will be announced to all Illinois hospitals and nursing homes as well as the Health Insurance Association of America, major consumer groups and Illinois Clinic Managers Association.

Slate '78 Interim House of Delegates Session

The 1978 Interim Session of the House of Delegates was scheduled for Nov. 4-5, at the Wagon Wheel Hotel, Rockton.

Hertz Auto Leasing Program

ISMS will mail to members information on behalf of Hertz concerning the firm's automobile leasing program, thus qualifying them for special discounts.

Illinois Medical Journal

The Board took the following action concerning the Illinois Medical Journal:

- Authorized continued free IMJ distribution to those emeritus and retired members who indicate each year—in response to a letter from the Publications Committee—they wish to receive the publication.
- Retained Neely Printing Co., Chicago, to produce IMJ in 1978.
- Authorized the Publications Committee to develop the concept of an IMJ editorial board that possibly would serve in lieu of an editor.

Revise Employee Retirement Plan

To obtain Internal Revenue Service approval of the ISMS Employees' Retirement Plan, the Society will revise the program so that employees will be 25% vested after two years, 40% vested after four years and an additional 10% each year thereafter. A staff committee will be appointed to suggest a method of providing appropriate ongoing staff input concerning the plan.

Executive Session (Minutes)

The executive session of the Board of Trustees with only members of the Board present was called to order by Dr. Robert T. Fox, chairman. The following actions were taken:

1. The feasibility of securing independent evaluation of the computer was referred to the Executive Committee. They are to report back to the Board at its next meeting.
2. The motion "This Board expresses its complete confidence in Executive Administrator Roger White," passed unanimously.
3. The motion "This Board finds no merit in the issues raised by the Will-Grundy County Medical Society in regard to the Executive Administrator," passed unanimously.
4. The motion "This Board welcomes any recommendations from any component society or individual member. Such matters should be directed to the Board through the appropriate Trustee and time for due consideration given before any publication. This and other actions of this executive session would be reported to the President of the Will-Grundy County Medical Society," passed unanimously.

The chairman declared the executive session ended. The Board was then called to order in regular session. All actions of the executive session were ratified. The Board was then adjourned.

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

Announcing . . .

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December 4, 1977

Sheraton-OakBrook Hotel

For further information contact:

Physician Recruitment Program
Suite 3510 — 55 E. Monroe
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CAIRO: PADCO Community Hospital seeking licensed physician for Emergency Room and Outpatient Department practice. Special consideration for physician experienced in working with physician's assistant. Guaranteed salary plus incentive bonus, fringe benefits and all supportive requirements provided. Rural community with excellent recreation opportunities. Medical staff privileges with general and specialty staff. Contact Harvey H. Pettry, Administrator, PADCO Community Hospital, 2020 Cedar Street, Cairo, Illinois 62914. Call collect-618/734-2400. Equal opportunity employer. (2)

CAIRO: Small Southern Illinois Hospital seeking two (2) Family Practice or General Practice physicians with present Illinois license or reciprocity status. Rural practice. Excellent salary guaranteed, fringe benefits. Office expenses and malpractice paid. Hospital will help one physician recruit second physician. Call 618/734-2400 or write Harvey H. Pettry, Administrator, PADCO Community Hospital, 2020 Cedar Street, Cairo, Illinois 62914. Equal opportunity employer. (2)

CHICAGO: Medical center position available. Top income to practitioner. Complete facility including X-ray and Lab. Contact: David Sternshein, 3138 W. Cermak Rd., Chicago 60623 (312-277-4505). (12)

CHICAGO: Board certified thoracic surgeon or pulmonary internist wanted for well-established corporate practice located in downtown Chicago. Salaried position with benefits and insurance. Practice out of sev-

eral northside hospitals. Call or write for application: The Head Chest Clinic, S. C., 55 E. Washington St., Chicago, 60602. 312-726-3437 (1)

CHICAGO: Area teaching hospital requires experienced, board certified roentgenologist. Top salary and full benefits will be offered to the candidate who meets our professional requirements. Respond in confidence: Box E.N., Physician Recruitment Program, ISMS, 55 E. Monroe, Chicago 60603. (1)

CHICAGO: Group practice requires American educated and trained surgeon (general). Board certified or eligible. Practice affiliated with up to date medical center facility. Respond in confidence: Box EH, Physician Recruitment Program, ISMS, 55 E. Monroe, Chicago 60603. (2)

CHICAGO: HALF-TIME EMPLOYEE HEALTH SERVICE PHYSICIAN: For progressive 372-bed university affiliated hospital, located on Chicago's northern lakefront. This is a part-time position, Monday-Friday, with the hours divided between the morning and afternoon. Excellent opportunity to initiate programs and provide leadership in developing a more comprehensive Health Service. Private Practice potential with office space, and teaching opportunities are also available. Candidates interested in pursuing this position further are invited to call or write to: Nancy Siegel, Staffing Specialist, Louis A. Weiss Memorial Hospital, 4646 N. Marine Drive, Chicago, Illinois 60640, (312) 769-2162. (2)

MACOMB: Western Illinois University—Staff Physician Opening; Enrollment 14,000. To provide general medical services for student patients. 40 hour work week; excellent retirement program; paid annual vacation, sick leave; hospitalization program; diverse cultural performing arts programs; major athletic programs; four year university with graduate school; 6 undergraduate colleges; small city rural environment; compensation competitive. Contact Vice President for Student Affairs, Western Illinois University, Macomb, 61455. (Ph. 309 298-1814) An EO/AA Employer. (1)

ROCKFORD: Psychiatrist, Board Certified or Board eligible with intention to obtain certification wanted for dynamic, growing corporate practice in Illinois' second largest city. Contact: Brian E. Tugana, M.D., Institute for Mental Sciences, 5670 East State Street, Rockford, IL, 61108—(815) 397-3177.

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This workshop is the first of a series of meetings designed to enhance the therapeutic skills of physicians who are involved in aiding impaired physicians.

The ISMS Panel for the Impaired Physician seeks to aid physicians who suffer from alcoholism and drug dependence. A goal of these workshops is improved and expanded Panel activity, through organization and evaluation.

November 14, 1977

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Viewbox

(Continued from page 251)

DIAGNOSIS: Pancreatic pseudocyst

The presence of a complete obstruction at the level of the bulbar portion of the duodenum in the presence of a pancreatic pseudocyst is highly unusual. Most obstructions, when they occur as a result of this lesion, are in the transverse duodenum. Examination by means of ultrasound and the presence of a markedly elevated serum amylase suggested that this obstruction was the result of a pancreatic pseudocyst. The patient was observed for about a week. A repeat GI (Figure 3) revealed a typical compression of the greater curvature of the stomach as well as the duodenal sweep by a mass in the head of the pancreas which was later verified surgically to represent a pseudocyst.

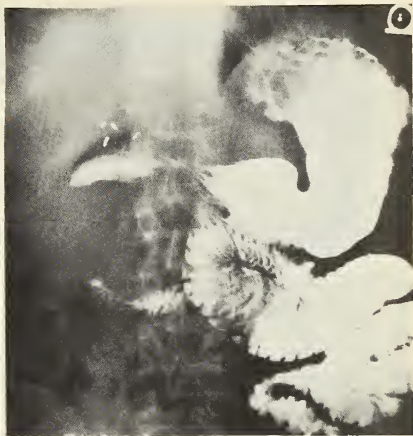


Figure 3

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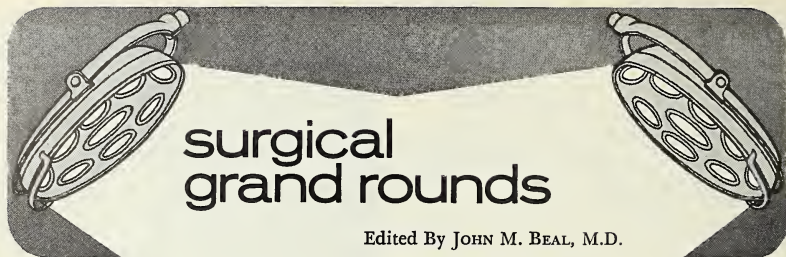
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surgical grand rounds

Edited By JOHN M. BEAL, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of March 23, 1976.

Case Report

Renal Transplantation

Dr. Jac Bellis: A 23-year-old white man was in apparent good health until March of 1973, when he developed morning headaches. Investigation by his physician revealed evidence of renal failure, including proteinuria, hematuria, azotemia, and hypertension. A renal biopsy was performed and showed chronic glomerulonephritis. His ASO and ANH and renal scan were within normal limits. In addition, a family history of renal disease was absent. He was treated appropriately with the customary measures, including prednisone for two years, but his disease gradually progressed.

In February of 1975, he was admitted to Northwestern Memorial Hospital as a candidate recipient for renal transplantation and for initiation of chronic hemodialysis.

The following laboratory values were significant: hematocrit, 24%; BUN, 75 mg %; creatinine, 5 mg %; total protein, 5.9 gm and creatinine clearance, 2 cc/minute.

Hemodialysis was instituted after creation of an A-V fistula in the left upper extremity. Between February, 1975, and January, 1976, his dialysis frequency was increased from once to

three times each week. His hypertension was extremely difficult to control and there was a persistent problem of chronic weight gain. Renal transplantation was recommended.

The donor was a 27-year-old white man, who had attempted to beat a freight train across a crossing and failed. The transplant service was alerted by the operating neurosurgeon that his brain damage was extensive and irreversible, and that his kidneys would be available for transplantation.

Forty-eight hours after operation, the patient ceased triggering the respirator and the EEG showed cessation of electrical activity. The kidneys were removed and the recipient was readmitted to Northwestern Memorial Hospital in anticipation of receiving the donor graft, pending results of the donor-recipient cross-match.

At this time, his hypertension was poorly controlled by medications including Aldomet® and Inderal®. With the exception of the hypertension, his physical examination was essentially within normal limits. Laboratory studies again revealed anemia and elevated BUN and creatinine levels. Cross-matching revealed donor-re-

cipient compatibility and preoperation preparation was done with oral Imuran® and intravenous steroids. Renal transplantation was performed the following morning.

The graft was placed extraperitoneally in the right iliac fossa in the standard fashion with an end-to-end intrailiac artery, renal artery and then renal vein, extra iliac vein, anastomosis was accomplished. In addition to the creation of a ureterocystostomy, the wound was closed without external drainage and the patient tolerated the procedure well.

Postoperative Course

Dr. Michael Floyd: Figure 1 shows the events occurring during this patient's 17-day stay in the hospital. He had a rather characteristic and benign postoperative course.

On day 1, he passed a rather large amount of urine, 5,000 mls. The serum creatinine preoperatively was very high, 18 mg/100 mls. The urine volume concerned us somewhat, since we felt it might presage a tubular necrosis, but in fact, it had a good specific gravity and a rather low sodium concentration of 30-35 milliequivalents per liter.

On day 2, our optimism was justified. The glomerular filtration rate (GFR) was 50 mls/min. He had already achieved $\frac{3}{4}$ of normal value for this function within 48 hours. The GFR increased for the first 8 to 9 days, and throughout he maintained a rather high urine volume. The serum creatinine came down to 1.5 mg/100 mls by day 9 and his weight showed a slight decline from preoperative value.

Immunosuppression during this period was fairly standard. During the first 48 postoperative hours when nothing was given by mouth, steroids were administered in the form of methyl prednisolone. He was also getting local graft radiation of 3 doses of 150 rads on days 1, 2 and 3. The other immunosuppressive given was Azathioprine®, 200 mg/day, which was tapered to 100 mg/day by day 5.

The only problem in his postoperative care surfaced on day 9, when there was a slight increase in his serum creatinine from 1.5 to 1.6 mg/100 mls, without a real change in clearance. Urine volume was slightly reduced. His weight had gone up slightly and his blood pressure was unchanged. However, the following day his creatinine clearance had dropped precipitously from 86 to 52 mls/min. His serum creatinine had not changed. He had gained two kilograms in weight and the diastolic pressure had gone from 200/100

to 200/120. He felt unwell, and was shivering. When we examined him, the kidney was palpably enlarged.

This was clearly a case of acute allograft rejection and the patient was given methyl prednisolone, half a gram each day intravenously. Oral prednisone was increased from 100 to 120 mg/day. He had a very satisfactory response. The creatinine clearance improved within 24 hours. His blood pressure also fell promptly at the time of treatment, his malaise resolved and the fever came down. There was a copious diuresis with a urine volume of 6 liters on the second day of treatment. He was discharged with a creatinine clearance of 90 mls/min on day 18.

Thus, the patient ran a typical but rather benign course for a cadaver kidney recipient.

Dr. Barry Kahan: Several points concerning renal transplantation are pertinent. I would like to introduce Mr. Paul Weeks, who administers organ procurement in our Transplant Section. This is a more serious problem today than ever before. The attitude of people on both the public and professional sides has been alerted to the important question of the definition of death. This has resulted in decreased organ donations. It is through the efforts of people like Mr. Weeks that we keep neurosurgeons and the public aware of our needs. Fortunately, we have received four cadaver kidneys during the last three months from the institution that provided this kidney.

(The patient enters)

Patient Interview

I now present the patient, who is willing to answer questions. Perhaps, first, you can tell the people how you feel now as compared to dialysis.

Patient: What I have now is a rebirth when compared to dialysis treatment. Dialysis is so restrictive. Your life is arranged around dialysis three days a week, five hours each time. There is also tremendous mental strain when you are on dialysis. After the transplant, it dawned on me what had taken place and I just cried, I was so happy. I never want to go back on dialysis, and I won't do anything to jeopardize myself so that I would have to go back on it.

Dr. John Beal: How is your general strength and appetite compared to that before you had the transplant?

Patient: I was restricted in both fluid and protein intake before the transplant. I love to eat. I used to be an athlete and I like being

COURSE FOLLOWING RENAL TRANSPLANTATION

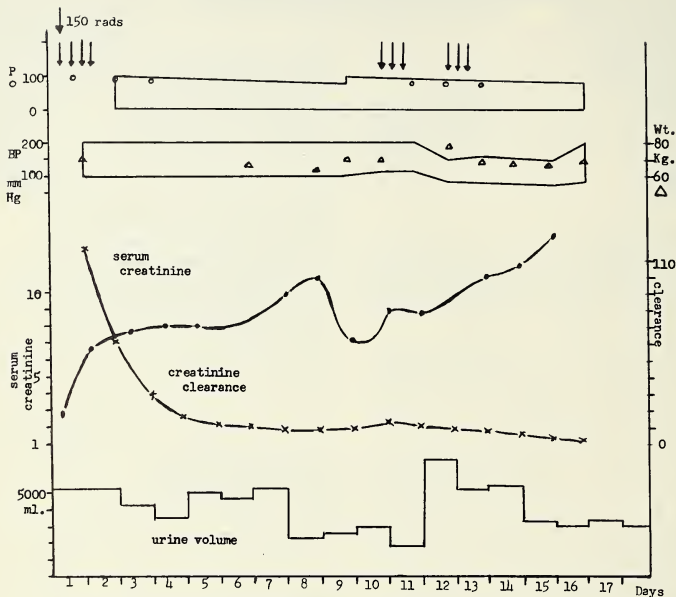


Figure 1
Chart presents course following renal transplantation.

active. When I came home from the hospital after the transplantation, I had no restrictions on what I could eat, so I ate well and gained 23 pounds in a couple of weeks. My appetite is fine and so is my strength.

(The patient leaves)

Dr. Barry Kahan: In the last few minutes, I would like to touch on another aspect of the cadaver kidney problem. The first is the procurement of cadaver kidneys; the second is the choice of the recipient for the cadaver kidney. This is the hardest issue we face. Who should actually get the kidney? Early on, when HLA typing was introduced, it was believed to be important for the matching. We now have very good evidence that it is not all important and that other factors

are probably more important. We realized early on that if we could employ the same immunologic analysis that we used after rejection to analyze patients before they were even transplanted, we might be able to sort out many of our problems.

Candidate Analysis

As you may know, 19 of the 71 cadaver donor transplants were rejected within the first week. This strongly suggested that we were transplanting kidneys into patients preimmunized against the antigens in those grafts. So, we initiated a multifaceted battery of immunological tests which covered every form of immune reactivity. The three primary aspects of this multifaceted battery are shown on the board. I should point

out that the CDA (complement-dependent antibody) test is the routine cross-match technique. All 19 early accelerated rejections had negative CDA determinations. So, obviously, they had other forms of immunity. Two other forms of immunity that we have been able to measure are cell mediated lympholysis (CML) and lymphocyte-dependent antibody (LDA). The CML test is performed by incubating the prospective recipient's lymphocytes with the donor's lymphocytes which have been labelled with Chromium⁵¹. The amount of Chromium⁵¹ released at the end of four hours is measured. This test of cell mediated lympholysis has demonstrated some cases wherein positive pre-existent reactions lead to severe rejection of subsequent transplants.

Probably the most sensitive test is the lymphocyte dependent antibody (LDA). In order to have cell lysis with complement, it is necessary to fix enough antibody molecules on each cell for complement to be cross-linked, leading to cell lysis.

On the other hand, the lymphocyte-dependent antibody (LDA) assays are more sensitive tests, since the fixation of only a few antibody molecules on the surface of the target cell will activate K (killer) cells to lyse that cell. The killer cell has an Fc receptor on its surface, which attaches to the Fc piece of the antibody molecule and then initiates lysis. Retrospective analysis revealed that 18 of the 19 patients who suffered accelerated rejection contained LDA activity. We have now used this battery on about ten patients prior to transplantation. In none of these were the tests negative and a rejection occurring in the first seven days. Therefore, we feel that the use of the multifaceted cross-match will reduce the number of early rejections, and may improve the overall course of the transplant recipient.

It is possible to do all these tests within 6 hours. We can admit potential recipients as soon as we know about the donor availability, begin to evaluate them, perform the immunological testing, and get them ready for transplantation within a short time after the donor nephrectomy.

Dr. John Beal: Dr. Kahan, this man had some evidence of acute rejection at about ten days. Is not this a fairly common event to have during the course of recovery which requires either irradiation or increase in prednisone? Also, if you have a good match, why does that occur?

Dr. Barry Kahan: The only thing we're ruling out by these tests is presensitization. We're

only ruling out CML and LDA activities on day zero. Our patient today did not have cells or antibodies that would react with the donor. We can't predict whether he is capable of becoming sensitized after grafting, that is, develop a primary immune response against the kidney. All we're avoiding is a secondary response or pre-existent immunity against the kidney.

I should mention that the second kidney was placed into another recipient. As soon as we were notified of the potential donor availability, tissue typing was performed and his lymphocytes were run in all the tests before we had removed the kidneys. We immediately ascertained that one patient—different from the one presented here—was compatible. So, we split the kidneys at the operating table, put one of them in slush, took that kidney directly and put it into the other patient, who has had one rejection episode at 20 days and is doing well at present. The second kidney was put on the preservation machine and perfused for about 18 hours prior to being implanted into today's patient the following morning.

Physicians,

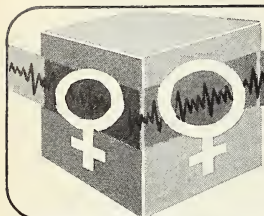
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KEY LINES:

BY BETTY SZEWCZYK, PRESIDENT, ISMSA

Focus on Course

Fall is "up-staging" the seasons and the leaves are drifting by—however, Auxiliary Year is progressing with force and purpose. State chairmen and officers have been diligently shaping programs for this special year and are beginning to see form and body. "Teach the Children" theme has opened many avenues, yet has created a continuity of purpose, a oneness in identity, and, we hope, a means of bringing about accomplishments for the needs and good of our young.

Community Health

"The diseases we thought were under control threaten us again and could reappear in epidemic proportions," we were told by AMA Past President Richard Palmer. The AMA Immunization Campaign is going straight to the children with a "Media Blitz" to make them aware of the need for immunization. To capture children's interest, the campaign uses a "hopscotch" theme. A series of commercials will be distributed to TV stations around the country. The spots are directed at both parent and child. They feature children playing on a colorful hopscotch court emblazoned with the names of such diseases as rubella, polio and diphtheria. The message is "Get Immunized."

Community Health Chairman Bonnie Keegan has been at work to make sure Illinois auxiliaries are prepared to play a crucial role in this campaign. Our members need only access to the school grounds and the ability to use a spray-paint can deftly. Sounds simple—but how effective if every school child played Immunization Hopscotch! Bonnie also represented ISMSA at

the steering committee meeting of the League for Nursing. The League will work nationally, as well as in Illinois, to raise childhood immunization levels and to improve activities and motivations regarding immunization for today and the future. This joint effort should abolish immunization problems.

Health Education

ISMSA has been aware of the need for school health education and has suggested that each auxiliary appoint a "school representative". This persons could be your health education or careers chairman and could cover each elementary, junior high and high school in the area. It is important to gather information about curriculum, teachers, nurses, other organizations, screening and educational materials being used. Once this job is done, the auxiliary would have a good basis to work toward better health education in the schools. Good rapport and access to the schools can initiate a program like the one State Chairman Diane Hinderliter is working on this year.

Together with the Illinois Heart Association, Auxiliary will attempt to get high school students involved in learning CPR. CPR means fighting for a life—it is a life-saving technique taught free of charge by the Illinois Heart Association. ISMSA will attempt to take this information into the schools. Students will learn what to do if a loved one or friend is stricken. Help must be given within five minutes of an attack. The average person can learn to perform CPR satisfactorily in about four hours. Diane hopes that county presidents and health education chairmen throughout the state will co-operate with this plan to teach cardiopulmonary resuscitation through regional contacts.

Family Health

Chairman Laura Ragar feels that the drug abuse and alcoholism among our state's young adults should carry emphasis this year in family health. She feels that most families know the basic facts about both diseases, but would like to give their children some alternatives. She suggests that the counties become active in initiating after-school lighted programs to encourage young adults to participate in extra-curricular activities at school. They can also support or start programs to help young adults find part-time jobs, and help them find volunteer programs of interest.

Safety

Safety Chairman Barbara Blumfield is enthusiastic about the CPR program. In addition, she is still touting "Is He Sick" pamphlets for kindergarteners, Heimlich Maneuver Posters, Baby-Sitter Info Sheets, and especially a new Bicycle Safety Program which involves a planned safety course in schools. Barbara is now investigating a slippery one—Skateboard Safety!

Children and TV

President-Elect Jane Klaren will pick up the "TV Violence" ball and run with it. She will be speaking at several district meetings on this topic, stressing that TV is not only a showplace of violence, but a wasteland of repeats. Over 98% of homes have at least one television set. It has been estimated that the average child has watched over 18,000 hours of TV by the age of 19—including 250,000 commercials. A "fun" attitude toward life is presented and problems are solved in sixty seconds. A confusing and unreal lifestyle desensitizes reactions and teaches peo-

ple to be withdrawn. Our children must not "make a friend" of this passive sport—they must learn to think, criticize, analyze and be selective about the programs they see.

Membership

Illinois was represented at the AMAA's Membership Workshop in Chicago by State Chairman Jean Hodges, Cook County Membership Chairman Barbara Friedell and Jessie Fulcher, Sangamon County Membership Chairman. They were introduced to a new concept for recruiting and retaining members called "Marketing Membership". A folder packed with ideas was presented to them and is available to each county. A sampling from this new resource is "The 5 Rs of Membership"—*Renew* the present membership; *Recruit* new members; *Refresh* the non-member; *Reactivate* the drop-out member; and *Register* with the resident and housestaff groups. Marketing membership is a positive approach—our product is our organization and its services.

Members-at-Large

MAL's continue to be a very important part of our membership and Chairman Rose David is dedicated to reaching every potential member-at-large in Illinois. She has suggested a method by which ISMS might find it possible to furnish Auxiliary with pertinent information regarding doctors' spouses and also a new form of billing to improve efficiency. MAL participation on a larger scale is the aim of this year's board.

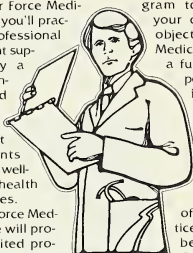
Project Bank

Program Vice-President Sharon Morris is the keeper of the Project Bank treasures. Contact her about information or questions regarding this fantastic resource—a central file of community projects done by auxiliaries across the country. The basic principle of the Project Bank is the deposit and withdrawal of information. Five easy steps to Project Banking: Identify community needs; evaluate auxiliary's manpower, interest, talent and time; make withdrawals by forwarding Project Bank Request Form to State Project Bank Coordinator or directly to Project Bank; deposit county's successful community projects in the Bank; use the Project Bank Information Sheet to "Bank-By-Mail." Forward your deposit to State Project Bank Coordinator. She will send it on to the Area Counselor; reinvest your increased interest and collect regular dividends. ◀

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EKG

(Continued from page 246)

Answers: 1. C. 2. E.

The 12 lead ECG demonstrates a sinus rhythm of 96 beats per minute. There are QS patterns all across the chest leads V1 and V4 with elevation of the ST segment. This is an acute antero-septal myocardial infarction. In addition the physical examination is in keeping with congestive heart failure. Therefore, all of the suggestions in question 2 are applicable. Our patient had elevations of all his enzymes and serial ECGs showed evolutionary changes of an acute myocardial infarction. His course otherwise remained uneventful.

COOK COUNTY

Graduate School of Medicine

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SPECIALTY REVIEW SURGERY, PART I, October 31
BASIC DERMATOLOGY, One Week, October 31
RECENT ADVANCES IN NEUROLOGY, November 7
RADIATION SAFETY IN DIAGNOSTIC RADIOLOGY, November 7
RADIATION ONCOLOGY, Four & a half days, November 9
UROLOGY FOR FAMILY PRACTITIONERS, 2 days, November 10
ADVANCES IN MEDICINE, One Week, November 14
FUNDAMENTALS IN OB & PED, 6 days, November 14
PSYCHIATRY FOR THE FAMILY PHYSICIAN, 2 days, November 15
SPECIALTY REVIEW UROLOGICAL PATH. & X-RAY, November 28
ADVANCES IN OBSTETRICS & GYNECOLOGY, November 28
SPECIALTY REVIEW SURGERY, PART II, November 28
ACUTE CARDIAC CARE, 3 days, November 30

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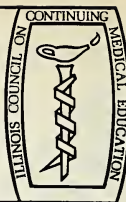
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Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

NOVEMBER

ANATOMY—CLINICAL HUMAN DEVELOPMENT

For: All physicians. Lecture, October 3-Nov. 28, 1977. Chicago, IL. Leslie Arey, M.D. CME Credit: 16 hrs. AMA Category 1. Fee: None. Sponsor: Northwestern University for Continuing Education, 301 E. Chicago Ave., Chicago, IL 60611. Contact: James E. Dyson, Ph.D. Telephone: (312) 649-8533.

SYMPOSIUM ON GERIATRIC ANESTHESIA

For: Anesthesiologists. Symposium, November 11-13, 1977. Marriott Motor Hotel, 1-70 at Lambert Int'l Airport, St. Louis, Missouri 63134. CME Credit: 15 hrs. AMA Category 1. Fee: None. Sponsor: Washington University School of Medicine, Office of Continuing Medical Education, 660 S. Euclid Ave., St. Louis, Missouri 63134. Contact: Loretta Giacalone, Administrative Coordinator. Telephone: (314) 367-9673. Co-Sponsor: St. Louis Society of Anesthesiologists.

Northwestern University Center for Continuing Education Monthly Calendar

For: All physicians. Northwestern University, 301 E. Chicago Ave., Chicago, IL. CME Credit: 1 hr. AMA Category 1. Fee: None.

Anesthesia
Dermatology
Internal Medicine
Neurology
Obstetrics & Gynecology
Ophthalmology
Orthopaedic Surgery
Otolaryngology and
Maxillofacial Surgery
Pediatrics
Psychiatry
Radiology
Surgery
Urology

For details on time and dates, contact: James E. Dyson, Ph.D., Director, Continuing Education, Northwestern University, 301 E. Chicago Ave., Chicago, IL. Telephone: (312) 649-8533.

Family Medicine

103rd ANNUAL MEETING OF SOUTHERN ILLINOIS MEDICAL ASSOCIATION
For: All physicians in Southern Illinois. Lectures, November 3, 1977, 8:05-4:00 PM. Augustine's Restaurant, Belleville, IL. CME Credit: 4 hrs. AMA Category 1. Fee: None. Reg. Deadline: November 3, 1977. Sponsor: Southern Illinois Medical Association, c/o Dale H. Rosenberg, M.D. Contact: Dale H. Rosenberg, M.D., Executive Sec'y., Treasurer. Telephone: (618) 398-5600.

Institutions Most Recently Receiving CME Accreditation

Columbus-Cuneo-Cabrini
Medical Center
Chicago
Grant Hospital
Chicago

Hinsdale Sanitarium & Hospital
Hinsdale
Riverside Hospital
Kankakee
Saint Joseph Hospital
Chicago
Shriners Hospital for
Crippled Children
Chicago
West Suburban Hospital
Oak Park

GYNECOLOGICAL LAPAROSCOPY

For: Gynecologists. Lecture, November 30, 1977—3 Days. Illinois Masonic Hospital (Cook County Graduate School), 707 S. Wood St., Chgo., IL. Speaker: John Barton, M.D. CME Credit: AMA Category 1. Fee: \$250.00. Reg. Limit: 80. Sponsor: Cook County Graduate School of Medicine. Contact: Robert J. Baker, M.D. Telephone: (312) 733-2800.

ADVANCES IN MEDICINE

For: Internists. Lecture, November 14, 1977. Cook County Graduate Sch. of Med., 707 S. Wood St., Chgo., IL. Speaker: Sheldon S. Waldstein, M.D. CME Credit: AMA Category 1. Fee: \$200.00. Reg. Limit: 100. Sponsor: Cook County Graduate Sch. of Med. Contact: Robert J. Baker, M.D. Telephone: (312) 733-2800.

CARDIOLOGY FOR FAMILY PHYSICIANS

For: Family Physicians. 1-day workshop course, November 9, 1977, 8:00 AM-5:00 PM. Towsley Center, Ann Arbor, Michigan 48109. CME Credit: 7 hrs. AAPF Prescribed, 7 hrs. AMA Category 1 and 7 hrs. AOA. Fee: \$60.00. Reg. Limit: 500. Sponsor: Office of Continuing Education, Dept. of Postgrad. Med. & Health Prof. Educ., Towsley Center, U-M, Ann Arbor, MI 48109. Co-Sponsor: Michigan Academy of Family Physicians. Contact: Connie Miller, Secretary. Telephone: (313) 763-1423.

SEVENTEENTH MEDICAL/SURGICAL SEMINAR FOR

SCIENCE COUNT
For: Physicians. Seminar, November 30, 1977, 8:15 AM. Mother Leonarda Hall, St. Therese Hospital, 2615 Washington, Waukegan, IL 60085. CME Credit: 4 hrs. AAPF Elective, 4 hrs. AMA Category 1 and 4 hrs. AOA. Fee: None. Reg. Deadline: November 28, 1977. Sponsor: St. Therese Hospital. Contact: R. M. Adelman, D.D.S., M.D. Telephone: (312) 688-5800.

Gynecology

Internal Medicine

Internal Medicine

Juvenile Diabetes

Neurology

RECENT ADVANCES IN NEUROLOGY

For: Neurologists. Lecture, November 7, 1977—One week. Cook County Graduate Sch. of Med. Speaker: Catherine Haberland. CME Credit: AMA Category 1. Fee: \$200.00. Reg. Limit: 100. Sponsor: Cook County Graduate Sch. of Med., 707 S. Wood St., Chgo., IL. Contact: Robert J. Baker, M.D. Telephone: (312) 733-2800.

Pharmacology

PSYCHOTROPIC DRUG MANAGEMENT

For: Primary care Physicians/Psychiatrists. 1-day workshop course, November 17, 1977, 9:00 AM-5:00 PM. Towsley Center, Ann Arbor, Michigan 48109. CME Credit: 6 1/2 hrs. AAPF Elective, 6 1/2 hrs. AMA Category 1 and 6 1/2 hrs. AOA. Fee: \$60.00. Reg. Limit: 400. Sponsor: Office of Continuing Education, Dept. of Postgrad. Med. & Health Prof. Educ., Towsley Center, U-M, Ann Arbor, MI 48109. Contact: Connie Miller, Secretary. Telephone: (313) 763-1423.

Psychiatry

DISTINGUISHED GUEST LECTURE SERIES

For: TBA. Lecture, November 17, 1977, 8:00 PM. Northwestern University, Ward Building, 1st floor, West, 303 E. Chicago, Chicago, IL 60611. Speaker: David Hamburg, M.D. CME Credit: 1 1/2 hrs. AMA Category 1. Fee: None. Sponsor: Institute of Psychiatry Northwestern University Medical School, 320 E. Huron St., Chicago, IL 60611. Contact: Leon Diamond, M.D. Telephone: (312) 649-8058.

Psychiatry

PRACTICAL APPLICATION OF DEVELOPMENTAL KNOWLEDGE

For: Psychiatrists/Mental Health Professionals. 2-day workshop course, November 4-5, 1977, 8:00 AM-5:00 PM. Towsley Center, Ann Arbor, Michigan 48109. CME Credit: 10 1/2 hrs. AAPF Elective, 10 1/2 hrs. AMA Category 1 and 10 1/2 hrs. AOA. Fee: \$60.00. Reg. Limit: 80. Sponsor: Office of Continuing Education, Dept. of Postgrad. Med. & Health Prof. Educ., Towsley Center, U-M, Ann Arbor, Michigan 48109. Contact: Connie Miller, Secretary. Telephone: (313) 763-1423.

Sarcoma

"SARCOMAS: ETIOLOGY, IMMUNOLOGY AND TREATMENT"

For: Physicians, Residents, Interns. Lecture, November 16, 1977, 11:00-12:00 noon. Martha Washington Hospital, 4055 N. Western Ave., Chicago, IL 60618. Speaker: Joseph G. Sinkovics, M.D. CME Credit: 1 hr. AAPF Elective and 1 hr. AMA Category 1. Fee: None. Sponsor: Medical Staff of Martha Washington Hospital. Contact: Fernando Villa, M.D. Telephone: (312) 583-9000 Ext. 331.

University of Illinois Department of Ophthalmology Weekly Clinical Conference

For: Ophthalmologists. Every Wednesday 4:00-6:00 PM, University of Illinois Eye & Ear Infirmary, 1855 W. Taylor St., Chicago, IL. CME Credit: 2 hrs. AMA Category 1. For more details contact: Cecile Wege, Sec'y, Continuing Education—Department of Ophthalmology. Telephone: (312) 966-8024.



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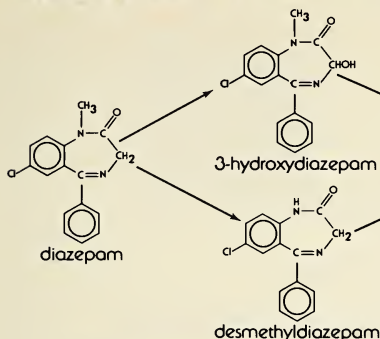
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Editorials



Government Controlled Medicine Cure-All or Health Hazard?

BY GEORGE T. WILKINS, JR., M.D.
ISMS President

Government-controlled national health insurance (NHI) is touted as the answer to rising costs as well as flaws in the health care system, but it may prove to be the nation's number-one health hazard.

The most radical NHI proposals pending in Congress would move the U.S. toward a national health service—similar to Great Britain's—where government wields total control over medical care. That would be disastrous. Washington already has demonstrated its inability to administer large-scale health programs by the 1976 swine flu fiasco and its handling of Veterans Administration hospitals, the Indian Health Service, Medicare and Medicaid.

NHI proponents point to rising health care costs as justification for increased government control, implying that a tax-financed system would mean "free" medical care. Nothing could be further from the truth.

Government medicine has proven to be the most expensive variety available, but its exorbitant cost is camouflaged as part of an individual's overall tax bill. A large portion of that cost can be attributed to government inefficiency:

- Private insurers can process Medicare claims for half what it costs the Social Security Administration, according to a Government Accounting Office study. These high administrative costs have been in part responsible for the 540% hike

in Medicare's portion of Social Security taxes since the program's inception in 1965.

- A hospital stay in a Veterans Administration facility often is double that in a private institution for identical treatment, according to a Government Accounting Office study. This reflects the experience in other countries which have adopted government-controlled systems. Lengths of stay average 13-19 days as compared to the U.S. average of approximately seven.

Even some federal agencies predict dire consequences if government expands its role in health care. The Congressional Budget Office and Council on Wage and Price Stability have cautioned that a tax-financed health care system would prove far more inflationary than the present system. The predictions are particularly significant because government has a history of underestimating costs of health care programs. Medicare expenditures were triple the projected rate in the first year alone.

Similar errors in projecting the cost of compulsory NHI could bankrupt the nation. Government estimates of a "cradle-to-grave" national health program run as high as \$2,400 for a family of four. If a margin of error similar to that in Medicare projections exists, the actual cost of comprehensive coverage could reach \$20,000 by the program's tenth year. More importantly, even if the NHI price tag was affordable,

the deterioration in quality and availability of care would exact a high price in health.

Converting to a tax-financed system would remove all direct patient payments, causing a tremendous increase in demand for medical services. However, there would be no corresponding increase in the supply of physicians and health facilities. The result would be assembly-line medicine and serious shortages—even rationing—of services.

In Great Britain, the public's demand for "free" medical care has proven insatiable, and finite resources have forced more than half a million Britons onto hospital waiting lists. Some will wait as long as four years for elective surgery and other treatment. Even patients classified as "urgent" must wait months. The seriousness of the situation was underscored by a *British Medical Journal* report that one hospital had 20 *unconscious* patients on an admission waiting list.

The average British doctor has 2,500 patients—more than triple the patient load of his U.S. counterpart. An American Medical Association study of the British system revealed that approximately 45% of those seeking treatment are not examined in any way. Instead, they merely are given prescriptions or placed on a waiting list.

A similar situation could be expected to develop in this country under a government-controlled system. Many patients already complain about long waits for physician appointments. With a Rand Corporation study forecasting a 75% jump in physician services if direct patient payments are eliminated, even longer waits could be expected.

Intense demand coupled with limited financial resources also restricts construction of health facilities and development of new technology. In Great Britain, most hospitals were built prior to the turn of the century, and their condition prompted one National Health Service director to refer to himself as "Britain's biggest slumlord."

Britain's long waiting lists and crumbling facilities are a stark contrast to the U.S. where medical care is readily available and hospitals offer the latest technological equipment. Unfortunately, the U.S. appears headed down the same path that led to chaos in Great Britain:

- The U.S. Supreme Court has ruled that patients have no constitutional right to choose their own doctor when medical care is provided through public funds.

- The Professional Standards Review Organizations (PSRO) law allows government bureau-

crats to force a patient out of the hospital against his physician's advice.

- The National Health Planning and Resources Development Act gives government officials considerable power to prevent hospitals from supplying certain services.

Increased government control also would cause a corresponding decrease in patient privacy. Constitutional safeguards against release of confidential medical records already are being flouted by government agencies at all levels, according to a report prepared for the National Bureau of Standards. Further violations of individual rights are inevitable under government medicine.

No citizen should be denied access to adequate medical care because of financial barriers. However, less than 10% of the population currently lacks basic insurance protection. Coverage for those citizens and protection against the costs of catastrophic illness could be afforded through modifications in the present system.

The U.S. health care system is acknowledged as the finest in the world. Discarding that system for government-controlled medicine would be hazardous to the nation's health. ◀

COOK COUNTY Graduate School of Medicine

CONTINUING EDUCATION COURSES STARTING DATES - 1977-1978

RECENT ADVANCES IN NEUROLOGY, November 7
RADIATION SAFETY IN DIAGNOSTIC RADIOLOGY, November 7
RADIATION ONCOLOGY, Four & a half days, November 9
UROLOGY FOR FAMILY PRACTITIONERS, 2 days, November 10
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November 28
ADVANCES IN OBSTETRICS & GYNECOLOGY, November 28
SPECIALTY REVIEW SURGERY, PART II, November 28
ACUTE CARDIAC CARE, 3 days, November 30
PLANNING FOR A DIAGNOSTIC RADIOLOGY DEPT., January 5
SPECIALTY REVIEW NEUROLOGICAL SURGERY, February 3
SPECIALTY REVIEW THORACIC SURGERY, February 13
NEUROPATHOLOGY, One Week, February 27
NEUROLOGY, PART I, BASIC, March 6
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* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetes with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other

adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids).

Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+ . Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions:

Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions;

nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

**FOR LONG-TERM CONTROL
OF HYPERTENSION*
SERUM K^+ AND BUN SHOULD
BE CHECKED PERIODICALLY.
(SEE WARNINGS SECTION.)**

SK&F CO., Carolina, P.R. 00630

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a SmithKline company

**Blue Cross®
Blue Shield®**



REPORT

FOR *Illinois Physicians*

Medical Necessity Program Implemented

In May an announcement was made by the Blue Shield Association, after consultation with medical specialty societies and health care professional organizations, that Blue Shield would no longer routinely pay for certain named surgical and diagnostic procedures. Additions have been made to the list since the original announcement.

Now Blue Shield is requesting physicians to submit with their Blue Shield Physician's Service Report, a statement indicating why a procedure on the following list was medically necessary. The statement will be reviewed by our Medical staff.

After the statement from the physician is reviewed by our Medical staff, a decision will be made to pay or deny payment of the Blue Shield claim. If the decision is to pay the claim, the hospitalization concomitant to the service will be paid by Blue Cross according to covered contract benefits. Conversely, if the Blue Shield claim is denied, any charge incurred for hospital services will also be denied by Blue Cross.

It will, therefore, be to the physician's advantage and to the advantage of the patient to consider the medical necessity of the listed procedures prior to their being performed. In the interest of high quality medical care at appropriate costs, Blue Shield is seeking the physician's cooperation in this mutually advantageous program.

If you have any medical questions relating to the Medical Necessity Program, please direct them to the Medical Department, Blue Cross and Blue Shield, 233 North Michigan Avenue, Chicago, Illinois 60601. Non-medical questions may be directed to our Professional Relations Department.

Each of the following procedures require a statement from the physician indicating why it was medically necessary.

PROCEDURES

Bronchoscopy—for sole purpose of injection of contrast medium for bronchography
Bronchoscopy—for sole purpose of injection of radioactive substance

Ligation of internal mammary arteries, unilateral and bilateral
Radical hemorrhoidectomy, Whitehead type, including removal of entire pile bearing area
Omentopexy for establishing collateral circulation in portal obstruction
Kidney decapsulation, unilateral and bilateral
Perirenal insufflation
Nephropexy: fixation or suspension of kidney (independent procedure), unilateral
Circumcision, female
Hysterotomy, non-obstetrical, vaginal
Fabric wrapping of abdominal aneurysm
Supracervical hysterectomy: subtotal hysterectomy, with or without tubes and/or ovaries, one or both
Uterine suspension (independent procedure)
Uterine suspension, with presacral sympathectomy (independent procedure)
Ligation of thyroid arteries (independent procedure)
Hypogastric or presacral neurectomy (independent procedure)
Angiocardiology, single plane and multi-plane, in conjunction with cineradiography
Angiocardiology, utilizing CO₂ method
Angiography—coronary, unilateral selective injection, single view unless emergency
Angiography—extremity, unilateral, single view unless emergency
Protein bound iodine (PBI)
Icterus index
Basal metabolic rate (BMR)
Phonocardiogram with indirect carotid artery tracing or similar study
Ballistocardiogram

Procedures:

Fascia lata by stripper
Fascia lata by incision and area exposure, with removal of sheath
Ligation of femoral vein, unilateral and bilateral
Excision of carotid body tumor without excision of carotid artery with excision of carotid artery
Sympathectomy, thoracolumbar, unilateral and bilateral
Sympathectomy, lumbar, unilateral and bilateral
Splanchnicectomy, unilateral and bilateral
Extra-intra cranial arterial bypass

For Sole Purpose of Treating:

Lower back pain
Lower back pain
Post-phlebotic syndrome
Asthma
Hypertension
Hypertension
Hypertension
Complete Stroke

The Economic Index Applicable for July 1, 1977 through June 30, 1978

Effective July 1, 1975 prevailing charges for physicians' services are subject to the National Consumer Price Index (economic index). The economic index limitation applies only to increases in prevailing charges; it does not affect customary charge calculations.

The economic index applicable to prevailing charges for physicians' services for the fiscal year 1978 will be 1.357; that is 35.7 percent above fiscal year 1973 levels. This economic index for the next 12 months represents a 6.35 percent increase over the economic index (1.276) used for the previous 12 months. Effective for claims filed at this time, the amount Medicare recognizes as the allowable charge for a physician's service during the present fee screen year can be no more than 35.7 percent higher than what was allowed for the same service during the 12-month period which ended June 30, 1973.

MULTIPLE PHYSICIAN BILLING FORMS

Medicare regulations have always required that the name of the physician who is treating the patient must be specified on the billing form. With passage of the "Government in the Sunshine Act" in March, 1977, this is even more important.

Whenever more than one physician is listed on a billing form or letterhead, the name of the physician that treated the patient should be circled, underlined, or identified in some way. An even better method is to affix one of the physician's Medicare labels to the bill before sending it to the patient.

The Medicare Carrier must maintain a separate fee profile for each physician, even though he may be a member of a group or corporation. Separate data is maintained showing the amount of Medicare payments made to each particular physician. If the billing form does not specify which physician rendered the service, the carrier will use the first physician listed as the provider of service. If the carrier must do this on all claims from a group, the figures for tax computation would appear as though all of the Medicare reimbursements were for one physician's services instead of distributed among appropriate members of the group.

The Department of Health, Education and Welfare requires that Medicare carriers conduct annual reviews of providers of medical services whose reimbursement from Medicare exceeds a given amount. The physician whose name appears first on a billing form could feasibly find himself in this position each year if the correct provider of services is not specified.

ITEMIZATION OF HOSPITAL VISITS

When billing Medicare for in-hospital visits, please specify the charge for the initial visit. The exact number of daily visits or follow-up visits should also be separated, as well as the charge per visit. For example:

9-1-77—Initial hospital visit \$0.00

9-2—9-9-77—8 follow-up visits @ . . . \$0.00

If visits are made to the intensive care unit, and an additional charge is made for such visits, they should be listed *separately* from the regular follow-up visits.

Clarification of a Listing on Clinical Laboratory Closings

Diagnostic Scanning Laboratory, Ltd., 6740 West Dempster St., Morton Grove, Illinois—Provider Number 14-8324—was inadvertently listed under the general heading: "Notices of Laboratory Closings," in the August issue of "Ask Blue Shield About Medicare," Illinois Medical Journal, referring to the closing of certain clinical laboratory services in the Medicare program.

The notice received from the Bureau of Health Insurance office, Social Security Administration, stated that the facility has ceased to provide *clinical laboratory services* under the Medicare program, effective June 25, 1977. The laboratory is, however, open for diagnostic scanning services.

Change in Participation, Ownership, Location of Labs

Notice was received from the Bureau of Health Insurance office, Social Security Administration of the following changes in participation, ownership and location of laboratories in the Medicare program.

The following laboratory has ceased operations and no payment can be made for services rendered on or after effective closing date:

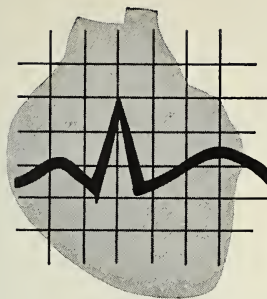
Illinois Medical Laboratory, Inc.
1420 North Milwaukee Ave.
Chicago, Illinois 60622
Provider Number: 14-8287
Effective Date: June 25, 1977

Change in Ownership:

Foster Western Laboratories, Inc.
5252 North Western Ave.
Chicago, Illinois 60625
Provider Number: 14-8078
Effective Date: April 26, 1977

Relocation:

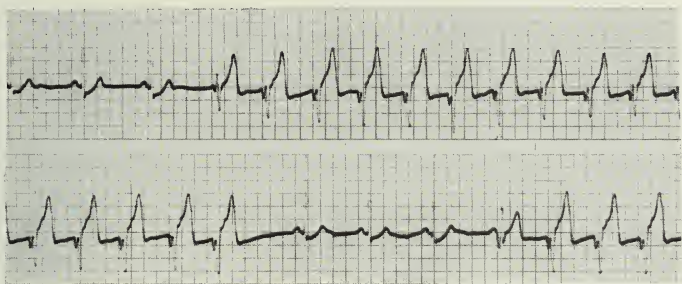
Gibbs Laboratory has re-located to 1824 Wilmette Ave., Wilmette, Illinois 60001, effective July 27, 1977. The Provider Number is 14-8237.



ekg of the month

JOHN F. MORAN, M.S., M.D., DAVID L. FISHMAN, M.D.,
PATRICK J. SCANLON, M.D., SARAH A. JOHNSON, M.D.,
JOHN R. TOBIN, M.S., M.D., AND ROLF M. GUNNAR, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

A fifty-nine-year-old man was admitted to the coronary care unit with a history of chest pain for two hours, nausea and diaphoresis. A diagnosis of inferior wall myocardial infarction was made. Serial enzymes demonstrated elevations in CPK, SGOT, and LDH. The patient remained stable with no change in blood pressure or evidence of heart failure. In the morning of the third day he developed the arrhythmia shown in the continuous rhythm strip from the monitor. During this time there was no change in blood pressure, no chest pains, or other symptoms. He was unaware of the change in his cardiac rhythm.



Questions:

1. The ECG rhythm strip shows:

- A. The development of bundle branch block.
- B. The onset of ventricular tachycardia.
- C. ST segment depression.
- D. Fusion beats.
- E. An accelerated idioventricular rhythm.

2. Treatment should include:

- A. Immediate use of intravenous lidocaine.
- B. Temporary demand pacemaker.
- C. Rapid digitalization.
- D. Careful, continued observation.
- E. All of the above.

(Answers on page 450)

THE LOWER G.I. TRACT ORGANICALLY SOUND



Celiac angiography is one of a number of highly specialized diagnostic techniques sometimes necessary to rule out organic causes of abdominal pain.

What's new at Bio-Science Chicago?

Always the latest specialized diagnostic tests.

Chemistry

Anti-convulsant group
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Ferritin in serum
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Riboflavin (B₂)
Succinimides in serum
Theophylline by HPLC
Uroporphyrinogen-1-synthetase

Endocrinology

Androstenedione in serum
Calcitonin
C-peptide
Estril in serum
Placental Estril in urine
HCG- β - subunit
Pregnanetriol in urine (GLC)
Prolactin
17-OH Progesterone in serum
Thyroglobulin in serum

Immunochemistry

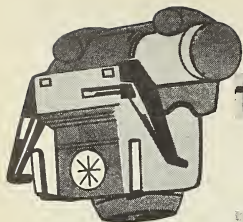
Anti-extractable nuclear antigen (Anti-ENA)
Beta 2-microglobulin
Fungus antibody group
Gentamicin
Intrinsic factor antibodies
Tobramycin
Anti-tissue antibodies

For information contact:
James A. Inkpen, Ph.D., Director



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Westmont, IL 60559
(312) 887-9800



the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This patient is a 45-year-old female with an increasing history of constipation and weight loss. (Figures 1, 2, and 3)



Figure 1



Figure 2



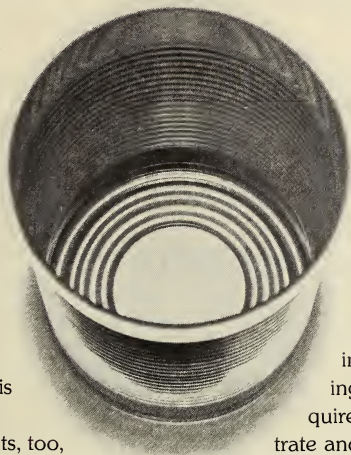
Figure 3

What's your diagnosis?

1. Endometriosis involving the colon
2. Multiple carcinomas of the colon
3. Metastasis to the colon
4. Granulomatous colitis

(Answers on page 438)

NOW a two-piece 14oz. can for Soyalac



A two-piece can means no soldered seam. No solder means no possibility of lead contamination from the container. Soyalac is the first infant formula with this packaging innovation.

There are improvements, too, in the formulation. Soyalac now has 25% more iron than known competitive hypoallergenic milk-free formulae. In fact, the entire formula has been slightly modi-

fied to reflect the current U.S. RDA levels set by the Food and Drug Administration.

Soyalac — formula for infants on regular feeding and for those who require milk-free diets; concentrate and single strength, ready-

to-use. Made from the whole soybean. I-Soyalac concentrate, made from soy isolate, with no soy carbohydrates and **no corn products.**



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SBS In Action

Why Do We Pretend Pathogenesis is Mysterious?

Heart disease constitutes the leading cause of death in this country today. Stroke, diabetes, and arteriosclerosis are also in the top 10 leading causes of death. In 1974 over one million people died from one of these. Why?

Volumes of information have been published on each pathology. The Western diet is a common theme in their etiologic discussion, and the theory has been endorsed by prestigious individuals and organizations. It has been repeatedly demonstrated that controlled input to the normal and pathophysiological mechanisms of the human body reduces morbidity and mortality. Why do we pretend pathogenesis is mysterious?

A germane clinical study of 241 patients between January 1, 1976 and December 1, 1976 has released preliminary information. The researchers, working from the Longevity Center in Santa Barbara, California, find that these diseases can be treated and/or prevented successfully. Nearly 90% of confirmed hypertensives (on medication at the outset) left the program normotensive and drug-free. In addition, they report 60% of confirmed insulin-using diabetics (maturity onset) left insulin free with controlled blood glucose levels. Gout patients left without medication and appreciably lower uric acid levels in 82% of the cases. Treatment of over 600 patients since the initial study has brought similar results.

The ISMS-SBS appointee to the Committee on Medical Service, Daniel Eisenberg, observed the program for six weeks and was thoroughly impressed. He has asked the Student Business Session to sponsor an educational seminar on the treatment, for physicians, medical students and allied health personnel.

Therefore, the ISMS-SBS is pleased to present "The Nutritional Dilemma in Medicine," to be

held at the Palmer House in Chicago on Friday, December 2, 1977, from 1:00 until 4:00 p.m. At the conference, Joseph Goldstrich, M.D., staff cardiologist at the Longevity Center and former National Director of Education and Community Programs for the AHA, will present two papers describing the treatment regimen and clinical results from the program.

Another recent advance in the application of sound nutritional principles in patient care is the advent of Total Parenteral Nutrition. Hyperalimentation has taken its place as an essential procedure in the treatment of severely debilitated patients. Dr. Mitchell V. Kaminski, M.D., one of the country's leading authorities in TPN, has agreed to discuss this therapy in the second hourly presentation entitled "Nutritional Assessment in Clinical Judgment."

"Food for Life and Our Economic Death Wish," will be the subject of a presentation by Louis Junker, distinguished professor of economics at Western Michigan University. His talk will consider the western diet as influenced by the food industry and its relationship to increased degenerative disease. Finally, he will consider alternative approaches open to physicians who seek to improve the general well being of patients through preventive management. Question and answer sessions will follow each presentation.

CME Category II credits will be awarded for attendance at the program. The conference is free of charge and refreshments will be provided. It may well be that the information presented will form the basis for a new era in medicine which, after years of approaching effective medical treatment for these major causes of death in our country, has finally reached its goal.

John Johnson, Chairman
Student Business Session, ISMS

Does it influence your choice of a peripheral/cerebral vasodilator*?

Vasodilan—compatible with coexisting diseases (e.g., glaucoma, diabetes)

Vasodilan has not been reported to affect the course of coexisting disease; it has not been reported to affect blood sugar levels or to raise intraocular pressure.

Vasodilan—compatible with concomitant therapy

Vasodilan has not been reported to affect the treatment of coexisting disease; it is compatible with such drugs as hypoglycemics and miotics.

Vasodilan—compatible with your total regimen for vascular insufficiency

Vasodilan can be a valuable adjunct in planning a total therapeutic program for vascular insufficiency.

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.

2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted. Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836



VASODILAN® 20-mg tablets

(ISOXSUPRINE HCl)

20 mg q.i.d. recommended dosage

Mead Johnson
LABORATORIES

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Generic Substitution Statute Changed

A consideration of physician responsibility under the amendment

On September 22, 1977, Governor Thompson signed into law H.B. 1650, as amended, which modified the Illinois Food and Drug Act and the Pharmacy Practice Act. Pharmacists now will be authorized to substitute different brands or a generic equivalent for prescribed medication if (1) the physician so allows; (2) the patient requests or agrees to it; (3) the dispensed product has a lower unit cost; and (4) the product is listed on a positive formulary developed by the Illinois Department of Public Health.

Section 1. Section 3.14 of the "Illinois Food, Drug and Cosmetic Act" approved June 29, 1967, as amended, is amended to read as follows:

(Ch. 56 1/2, par. 503.14)

Sec. 3.14. Dispensing or causing to be dispensed a different drug in place of the drug or brand of drug ordered or prescribed without the express permission of the person ordering or prescribing. However, nothing in this Section shall prohibit the substitution of different brands of the same generic drug, based upon a positive drug formulary listing which is developed, maintained, and issued by the Department of Public Health under which substitution within a generic class or of specific products for those prescribed is permitted. Determination of products which may be substituted shall be recommended by a Technical Advisory Council of said Department, selected by the Director of Public Health, which council shall consist of 7 persons including 2 physicians, 2 pharmacists, 2 pharmacologists and one other prescriber who have special knowledge of generic drugs and formularies. Technical Advisory Council members shall serve without pay, and shall be appointed for a 2 year term: the terms of the initial council shall commence with the effective date of this amendatory Act. The drug formulary listing shall be promulgated by the Director. The Technical Advisory Council shall take cognizance of Federal studies, the National Formulary or its successor, the U.S. Pharmacopoeia, or other recognized authoritative sources, and shall advise the Director of any necessary modifications at least every 3 months.

An initial drug formulary shall be issued and operative as promulgated by the Director within 9 months of the effective date of this amendatory Act, with prior notice of its content to every pharmacist and prescriber at least 30 days prior thereto. Thereafter amendments or

modification of said formulary shall be furnished all pharmacists and prescribers by timely notice from the Department. The Department shall issue necessary rules and regulations for implementation.

Section 2. Section 11 of the of the "Pharmacy Practice Act", approved July 11, 1955, as amended, is amended to read as follows:

(Ch. 91, par. 55.11)

Sec. 11. No person shall compound, or sell or offer for sale, or cause to be compounded, sold or offered for sale any medicine or preparation under or by a name recognized in the United States Pharmacopoeia or National Formulary, for internal or external use, which differs from the standard of strength, quality or purity as determined by the test laid down in the United States Pharmacopoeia or National Formulary official at the time of such compounding, sale or offering for sale. Nor shall any person compound, sell or offer for sale, or cause to be compounded, sold, or offered for sale, any drug, medicine, poison, chemical or pharmaceutical preparation, the strength or purity of which shall fall below the professed standard of strength or purity under which it is sold. When the physician or other authorized prescriber, when transmitting an oral or written prescription, indicates that there may be substitution, a different brand name or non-brand name drug product of the same generic name may be dispensed by the pharmacist, provided that such substituted drug has a unit price less than the drug product specified in the prescription and provided that the substitution has been permitted by a regulation issued by the Department of Public Health pursuant to Section 3.14 of the "Illinois Food, Drug and Cosmetics Act", approved June 29, 1967, as amended. On the prescription forms of prescribers, must be placed the words, "may substitute" and "may not substitute". The prescriber must then check either of these alternatives and, in his or her own handwriting, personally write his or her signature, beside the selected alternative, to guide the pharmacist in filling the prescription. If a prescribing physician checks the alternative "may substitute", or fails to check and to sign beside one of the alternatives, the pharmacist may substitute in accordance with this Act. The physician's signature used to indicate the alternative of "may substitute" or "may not substitute" will also authorize the issuance of the prescription. When a person presents a prescription to be filled, the pharmacist to whom it is presented may inform the person if the pharmacy has in stock a different brand name or nonbrand name of the same generic drug prescribed and the price of such different brand name or nonbrand name of such drug product. If the person presenting the prescription is the one

to whom the drug is to be administered, the pharmacist may fill the prescription with the brand prescribed or a different brand name or nonbrand name product of the same generic name that has been permitted by the Department of Public Health, if such drug is of lesser unit cost and the patient is informed and agrees to the substitution and the pharmacist shall enter such information into the pharmacy record. If the person presenting the prescription is someone other than the one to whom the drug is to be administered the pharmacist shall not fill the prescription with a brand other than the one specified in the prescription unless the pharmacist has the written or oral authorization to substitute brands from the person to whom the drug is to be administered or a parent, legal guardian or spouse of that person.

In every case in which a substitution is made as permitted by the Illinois Food, Drug and Cosmetic Act, the pharmacist shall indicate on the pharmacy record of the filled prescription the name and address or other identification of the manufacturer of the drug which has been substituted.

A substitution of any drug by a pharmacist shall not constitute evidence of negligence if the substituted drug was included in the drug formulary listing. Failure of a prescribing physician to specify that no substitution is authorized does not constitute evidence of negligence unless the practitioner has reasonable cause to believe that the health condition of the patient for whom the physician is prescribing warrants the use of the brand name drug and not another.

The Department of Public Health shall have the duty of monitoring the cost savings effected by substitution, and shall issue rules and regulations to effect such monitoring, and shall annually report to the legislature as to cost savings being achieved. The department is authorized to employ an analyst or chemist of recognized or approved standing whose duty it shall be to examine into any claimed adulteration, improper substitution, alteration, or other violation hereof, and report the result of his investigation, and if such report justifies such action the department shall cause the offender to be prosecuted.

While some aspects of this change in the statute are clear, confusion may exist on certain points. The bill does not identify how controlled substances are to be prescribed or if substitution will be allowed. Of greater concern are "designated products" in Schedule II, which must be prescribed on official state triplicate forms.

A serious, unresolved question relates to potential liability for an adverse reaction. If the pharmacist does substitute, is the physician liable? Would there have been no adverse reaction if substitution had not been made? Physicians should exercise caution in allowing substitution if a risk of adverse reactions to a substitute exists.

The new law is vague about the physician's signing of the prescription. While an unsigned prescription is invalid, the law implies that an unsigned script can be used if substitution is made. If the physician checks a box, but doesn't sign, it seems to indicate the substitute product can be dispensed. An unresolved question is what would happen if a box is checked, but the signature is on the other line.

This bill has been viewed as "consumer" legislation. It allows dispensing of a substitute product, with a lower unit price, but provides no mechanism to guarantee that the lower price will be passed along to the consumer.

ISMS is working with the Department of Public Health in development of an approved form for prescriptions. When available all members will be notified.

Any member who has questions about the new law, personal liability, or other aspects of this, should contact personal counsel. Physicians are reminded that it is the right of the prescriber to indicate whether substitution may be made. He may act in an affirmative way to make judicious use of the ability to allow substitution.

Why Do We Pretend Pathogenesis is Mysterious?

*Heart Attack, Stroke, Diabetes,
Hypertension can be Prevented*

*The ISMS-SBS presents an
educational seminar on the effective
treatment of degenerative disease.*

Guest Speakers:

Joseph Goldstritch, M.D., former National Director of AMA Community Health and Educational Programs, staff cardiologist, Longevity Center.

Louis Junker, Ph.D., distinguished professor of economic nutrition, Western Michigan University

Mitchell B. Kaminski, M.D., leading authority in Total Parenteral Nutrition.

Chicago Palmer House

Friday, December 2, 1977

CME Category II Credit 1:00-4:00 p.m.

Refreshments

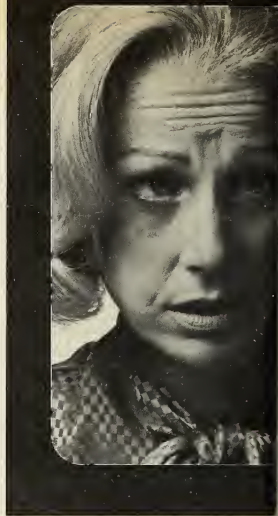
Free Admission

Clinics for Crippled Children Listed for December

Thirty-two clinics for Illinois' physically handicapped children have been scheduled for December by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-two general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination, along with medical social and nursing services. There will be eight special clinics for children with cardiac conditions and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- December 1 Sterling—Community General Hospital
- December 1 Springfield—St. John's Hospital
- December 1 Effingham—St. Anthony's Memorial Hospital
- December 1 Lake County Cardiac—Victory Memorial Hospital
- December 2 Division Cardiac—U. of I. at the Medical Center
- December 6 East St. Louis—Christian Welfare Hospital
- December 7 Rockford—St. Anthony's Hospital
- December 7 Rock Island Cerebral Palsy—Foundation for Crippled Children and Adults
- December 7 Hinsdale—Hinsdale Sanitarium
- December 8 Litchfield—St. Francis Hospital
- December 8 Kankakee—St. Mary's Hospital
- December 8 West Frankfort—Union Hospital
- December 9 Chicago Heights Cardiac—St. James Hospital
- December 12 Peoria Cardiac—St. Francis Hospital
- December 13 Belleville—St. Elizabeth's Hospital
- December 13 Peoria—St. Francis Hospital
- December 14 Springfield Pediatric Neurology—St. John's Hospital
- December 14 Chicago Heights General—St. James Hospital
- December 14 Carmi—Carmi Township Hospital
- December 14 Champaign-Urbana—McKinley Hospital
- December 14 Aurora—St. Joseph Mercy Hospital
- December 14 Joliet—St. Joseph's Hospital
- December 15 Rockford—Rockford Memorial Hospital
- December 15 Bloomington—Mennonite Hospital
- December 15 Elmhurst Cardiac—Memorial Hospital of DuPage County
- December 16 Chicago Heights Cardiac—St. James Hospital
- December 16 Evanston—St. Francis Hospital
- December 19 Peoria Cardiac—St. Francis Hospital
- December 19 Maywood—Loyola Medical Center
- December 20 Peoria—St. Francis Hospital
- December 20 Rock Island—Moline Public Hospital
- December 27 Park Ridge Cardiac—Lutheran General Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local, social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.



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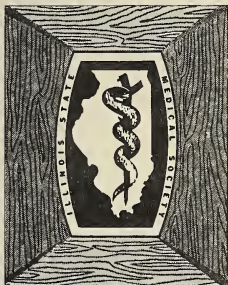
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I M J

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Reconstructive Breast Surgery

ROBERT M. SWARTZ, M.D. F.A.C.S. AND
ROBERT E. KNODE, M.D., F.A.C.S./ARLINGTON HEIGHTS AND CHICAGO

Plastic surgical reconstruction of the breasts can be performed for many women who have undergone mastectomy for carcinoma. Approximately 70,000 women in the United States require mastectomy each year and over 50% are apparently cured of disease. Many of these cures can be projected soon after mastectomy.

To those patients whose life is diminished in quality by mastectomy one can offer a reconstructed breast substitute. The treatment of fibrocystic disease of the breast by subcutaneous mastectomy and reconstructive mammoplasty can be considered for women in whom hyperplastic, possibly pre-malignant, cellular changes are present on breast biopsy. Better liaison between general and plastic and reconstructive surgeons will offer a great deal to women whose breasts form an important part of the body image.

From the entire spectrum of reconstructive procedures performed by plastic surgeons on the female breast, the two most commonly performed are subcutaneous mastectomy with reconstruction and post-mastectomy breast reconstruction.

Subcutaneous Mastectomy

Subcutaneous mastectomy is most often performed for fibrocystic disease of the breast, particularly where microscopic evidence of pre-

malignancy is present. These changes may include ductal hyperplasia with or without atypia, calcification in association with epithelial structures, papillomatosis, and lobular hyperplasia.¹ Some authorities believe that any epithelial proliferative lesion of the breast is associated with an increased risk of subsequent carcinoma in that organ. The risk over a 20 year follow-up period is two to three times greater than the risk found in women without epithelial proliferative lesions. Atypical proliferative lesions resembling lobular carcinoma *in situ*, but not so severe as

to occasion this diagnosis, are associated with the greatest increased risk (about five times that of women without epithelial proliferative lesions).² Other changes such as cysts, sclerosing adenosis, and apocrine metaplasia do not, in themselves, represent pre-malignant changes. They can, however, complicate physical differentiation from a carcinomatous breast mass.

Xerography may be helpful in determining the severity of fibrocystic disease in relationship to its status as a pre-malignant problem. Here the classification of Wolfe³ may be useful, particularly where there is radiographic evidence of dysplasia. Evidence includes increased radi-density over and above that of fat, but without the prominent duct pattern as the dominant feature. In its most severe form, the parenchyma will appear homogeneous. Pathologic correlation reveals that these breasts present the histologic characteristics of severe mammary dysplasia with a great deal of desmoplasia. The various forms of fibrocystic disease must be differentiated if one is to understand clearly the indications (i.e. potentially pre-malignant situations) for subcutaneous mastectomy.

Careful consideration of subcutaneous mastectomy should be given in prophylactic treatment of the contralateral breast following mastectomy for carcinoma. This is particularly true of women in the high risk category. These include the young patient, those with family history of carcinoma and those with multiple contralateral (possibly fibrocystic) breast masses.

Subcutaneous mastectomy has been criticized by many surgeons who feel that it is an inadequate form of mastectomy. If properly performed, however, the procedure can mimic the degree of breast removal in a simple mastectomy. Only by employing an adequate (approximately 9-10 cm) inframammary incision (or other variation of the approaches to subcutaneous mastectomy) can appropriate exposure of the breast area and identification of the surgical landmarks for mastectomy be carried out.

The accompanying illustration (Fig. 1) shows an operative photograph of such a subcutaneous mastectomy revealing the large volume of breast parenchyma, including the axillary tail of Spence, which can be removed with proper exposure through a large inframammary incision. The smaller incision classically used for augmentation mammoplasty is to be condemned for what is, by definition, an extirpative procedure. With proper exposure, the breast tissue underlying the areola can be visualized and sharply



Figure 1
Intra-operative photos of subcutaneous mastectomy through generous inframammary incisions.

excised from the overlying nipple and areola leaving only a very small amount of breast ductal tissue adherent to the overlying structures.

Because of the extent of the mastectomy and the thinness of the overlying skin and subcutaneous fat flap, it is our general habit to delay reconstruction for a period of about 6-12 weeks. This avoids the potential hazard of immediate

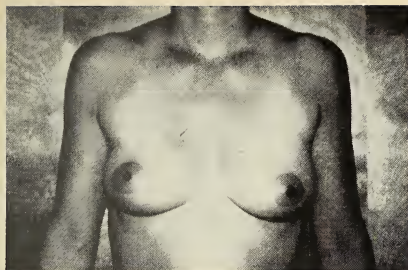


Figure 2
Preoperative photos of patient with severe fibrocystic disease of breasts.

reconstruction with its increased incidence of skin breakdown. Immediate reconstruction can be carried out, however, in selected patients under proper circumstances.

Reconstruction, whether immediate or delayed, is performed with silicone prosthesis or a biphasic inflatable and silicone prosthesis. The initial surgical incision is re-opened and the subcutaneous or retropectoral plane dissected to attain a space for the implant insertion. If retropectoral placement is chosen, it may be necessary to free at least a portion of the sternal original of the pectoralis major muscle from the sternum for proper positioning of the prosthesis. This seems to give no functional disability.

It should be noted that this operation should not be offered to the patient as a cosmetic triumph nor should it be considered in any way analogous to augmentation mammoplasty. The

surgeon should likewise point out to the patient that there is a near 100% incidence of nipple anesthesia following this procedure. In most cases, however, the reconstructed breast is a very adequate substitute for the normal breast from a cosmetic point of view. (Fig. 2 and 3)

A protocol of four quadrant needle biopsies of the breast has been proposed for premenopausal patients with multiple breast masses to determine the degree of pre-malignant change present in an individual patient's breast. This is followed by a period of attempted progestational hormone suppression of these changes and by repeat needle biopsy. One might strongly urge subcutaneous mastectomy for those premenopausal patients with "non-hormone suppressible" hyperplastic changes, or the postmenopausal patient with hyperplastic changes.⁴ No definite decision can be reached as yet as to the efficacy or value of this plan.

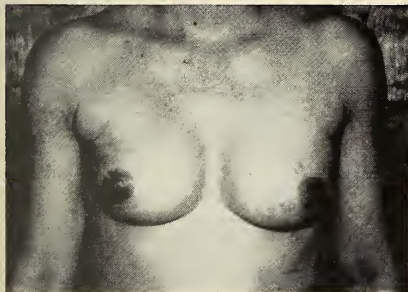


Figure 3
Postoperative photos of patient who has undergone bilateral subcutaneous mastectomy and silicone implant reconstruction.



Figure 4
Photos of patient after right modified radical mastectomy for intraductal carcinoma.

Post-Mastectomy Reconstruction

Post-mastectomy reconstruction of the female breast is being performed with growing frequency. More recently, some women are sent for consultation to discuss their options for reconstruction prior to the initial mastectomy. This approach demonstrates to the patient that reconstructive procedures are available if desired. It can serve to diminish apprehensions regarding possible disfigurement. The increasing use of pectoralis muscle-preserving procedures and also transverse incisions leaving a post-mastectomy site more amenable to recon-

struction should result in more potential candidates for later reconstruction.

The timing of this reconstruction is open to great controversy and should be individualized. It would seem that early reconstruction should be performed in a case where cure is expected, particularly where local (skin) recurrence is unlikely. Patients with large, bulky, or skin invasive carcinomas would, of course, be poor candidates for early reconstruction. Thus, plans for reconstruction must be individualized with the earliest reconstructions (6-12 months) reserved for those patients with small lesions not encroaching on incisional areas or chest wall. A more conservative approach must be taken to larger and more aggressive histologic types of tumor and reconstruction delayed possibly three to five years. Of course, the chance that local recurrence may occur in even well selected patients must be discussed preoperatively with all patients.

Surgical Technique

In most cases an adequate breast mound can be constructed using a silicone or biphasic inflatable silicone prosthesis placed beneath the skin, subcutaneous tissue, and possibly residual pectoralis major muscle. Later a nipple facsimile can be constructed using a labia minora or

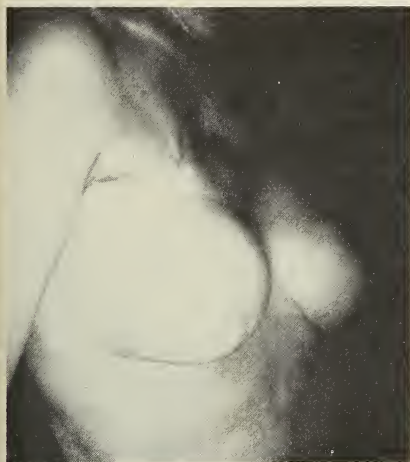


Figure 5

Patient after reconstruction of right breast with biphasic silicone and inflatable prosthesis.

contralateral nipple graft. In some cases a nipple excised at the time of mastectomy can be "banked" in the inguinal area for further use in reconstruction. It should be noted that a majority of patients are quite satisfied with the reconstructed breast mound and bypass the later nipple reconstruction as "unnecessary." (Fig. 4 & 5)

Those patients who have undergone a formal radical mastectomy, particularly where postoperative radiotherapy has been necessary, present more complex problems in breast reconstruction. Here it is first necessary to transfer new tissue to the mastectomy site with a local upper

abdominal flap or distant tube pedicle flap. Only those patients who are particularly well motivated for this longer period of surgical rehabilitation are acceptable candidates for it, and then only after thorough instruction as to the many potential pitfalls along the way should reconstruction be started. However, to some patients these hazards are worth the risk and the results are most gratifying in the motivated patient.

Case History

A 47-year-old white female was referred for plastic surgical consultation by a general surgical colleague. She related a long history of

"cystic disease" of the breasts. A recent xeromammogram had shown a radiodensity in the supra-areolar area of the patient's right breast. Her mother had recently undergone a mastectomy for carcinoma. Physical examination showed a 2 cm area of induration in the upper central area on the right side. The various procedures for breast reconstruction following mastectomy and the determining factors in the advisability of subcutaneous mastectomy were discussed with her at this initial visit.

Subsequently right breast biopsy was carried out. Permanent sections of this material returned lobular carcinoma *in situ*. Further consultation and discussion of the treatment possibilities was held. Soon thereafter, in a combined general and plastic surgical effort, a right simple mastectomy and left subcutaneous mastectomy were performed. For the simple mastectomy a transverse incision was chosen to allow for satisfactory reconstruction of a breast mound. The right nipple was removed as a composite graft and "banked" on the skin of the left lower abdominal quadrant. Postoperative recovery was uneventful. Final examination of tissues revealed residual foci of lobular carcinoma *in situ* in the right breast and changes consistent with fibrocystic disease of the left breast. Multiple sections of sub-areolar breast from the right side were negative for carcinoma.

Approximately three months after this procedure, bilateral breast reconstruction was performed using biphasic silicone-inflatable prostheses placed in a retropectoral position. Final replacement of the nipple graft on the right breast mound should complete reconstruction. Photographs are shown at the various stages of mastectomy and reconstruction to date. (Fig. 6 & 7)

Psychological Benefits

There is little evidence to support the concept that surgical invasion of the mastectomy area by reconstructive procedures accelerates or causes the recurrence of carcinoma. The importance which an individual places on reconstruction of the breast mound should play an important part in determining the timing for reconstruction. Points to be clearly understood by the patient should include the cosmetic shortcomings of most breast reconstructive procedures and the fact that the purpose of the procedure is to aid her in dress and activities where an external prosthesis is clumsy or embarrassing.

The importance of this reconstruction on re-establishing the patient's "body image" cannot be over-emphasized. The patient's roles of mother, wife and lover can only be enhanced by this positive self image. Improved "quality of life" following these procedures plays as important a role in reconstructing the patient's psyche. Whereas one cannot predict which candidates for reconstruction will take advantage of these procedures, we feel it is extremely important that they be able to make the choice themselves.

We would hope that knowledge of available reconstructive procedures will discourage delayed treatment of a breast "lump" in patients who fear the disfigurement of mastectomy.

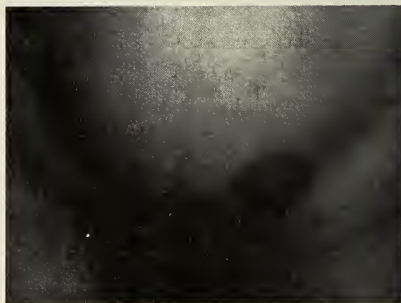
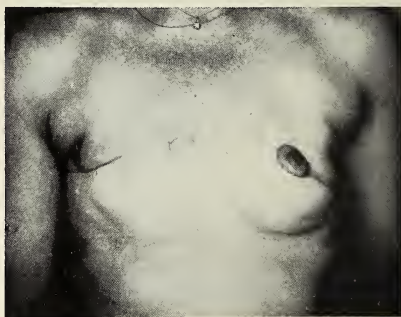


Figure 6

Patient after right simple mastectomy for lobular carcinoma *in situ* and left subcutaneous mastectomy for fibrocystic disease. The right nipple is "banked" in the left lower abdominal skin for use in later reconstruction.



Figure 7

Patient after reconstruction of breast mounds bilaterally. Replacement of right nipple is to be carried out in several months.

Conclusion

Much can be accomplished in consultation and teamwork between the general, and plastic and reconstructive surgeon. Through this interaction, suitable procedures can be designed for nipple preservation (where allowable) and mastectomy procedures allowing for satisfactory reconstruction at no compromise in the possibility of performing a curative mastectomy for neoplasm. Only through such liaison can the maximum benefit be offered to the patient in surgical treatment and subsequent reconstruction of the breast area. The rehabilitation of the mastectomy patient, both physical and mental, should be an important consideration in the management of the breast carcinoma problem. ◀

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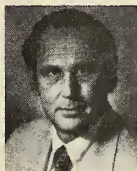
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Acknowledgement

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Early Screening for Spinal Defects

Quasimodo. Most people are familiar with the story of the hunchback of Notre Dame. Lon Chaney's portrayal depicts him climbing among the parapets and gargoyles of the cathedral, taunting the crowds. This story reflects the plight of an unfortunate individual, out of step with society, afflicted with a terrible disfigurement and obviously in pain at times, who became a social outcast.

Could early screening and identification of his infirmity, possibly scoliosis, have prevented this?

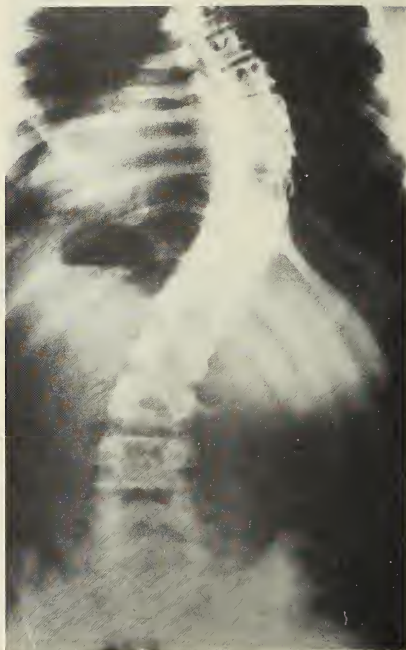
Scoliosis. What is it? Many physicians, of course, are familiar with the young child whose routine examination shows that one shoulder is a little lower than the other, that one shoulder blade seems a little fuller than the other, or that the waist line does not run parallel to the floor. Often this may be put aside as a quirk. In truth, it is sometimes an early symptom of a lateral curvature which can progressively worsen. Kyphosis, or round back as it is commonly termed, is a related disorder. This, too, can be identified at an early age.

Until approximately 20 years ago, it would have been difficult to treat Quasimodo or any other persons afflicted with scoliosis. Lateral curvature of spines had been identified, but science had not yet perfected techniques which would allow demonstrably effective early intervention.

... at the minimum, an estimated one million Americans have a significant degree of scoliosis.

With the advent of bracing techniques, as well as procedures for operative pinning of the spine, many people were relieved and their afflictions alleviated to a great extent.

Statistics vary as to the incidence of scoliosis and further etiologic and epidemiologic studies are needed. Some authors have cited an incidence rate as high as 14% in the school-age population; however, more recent data seem to indicate that a smaller number may be affected to the extent that scoliosis can be identified and treat-



ment may be needed. This would mean that, at the minimum, an estimated one million Americans have a significant degree of scoliosis.

Various screening programs have found that as many as 4% of children 10 to 14 years of age show some signs of scoliosis, but in most the curvature is slight. Often it does not progress to the point where treatment is needed, but cases which do not require treatment should be monitored. While statistics vary, it is estimated that about 2% of the children who are identified as having signs of scoliosis require treatment or continued medical observation.

In most screening programs, the detection of some degree of scoliosis is about equal in girls and boys. However, the condition becomes severe

enough to require treatment in many more girls than boys, usually at the ratio of eight to one. The reason for this has not yet been identified. In addition, no cause for scoliosis itself has been determined.

Progression

In the small number of cases where the condition initiated in childhood worsens, it progresses most rapidly during the growth-spurt years of adolescence. As the curvature progresses, the rib cage is forced into an unnatural position. The curvature may be a rotation of the spine as well as a bend. The ribs on one side are pushed out and away from the body, on the other side they turn forward and in. This rotation ultimately leads to a permanent hump on one side of the upper back.

The earlier this spinal deformity is detected, the better the response to treatment and the more likely that brace treatment can be effective and surgery will not be required. It is very important that young people who have scoliosis or kyphosis are identified at early, mild, developmental stages. Without screening, many young people who are victims of scoliosis or kyphosis may require major surgery. The surgery may bring less favorable results than had the condition been uncovered earlier and treated with a brace. In addition, if the untreated disability progresses there can be a severe effect on cardiopulmonary functions. In the extreme it can impinge functions of the spinal cord. Related to this may be development of arthritis and related pain. It goes without saying that the severe psychological effects of such a deformity are very serious.

Identification and Education Activities

Screening large numbers of young people appears to be the best way in which spinal in-

Without screening, many young people who are victims of scoliosis or kyphosis may require major surgery.

firmities are likely to be detected in their earliest stages. Recently the states of Delaware and Minnesota instituted screening programs. In Delaware it was part of the school program at the elementary level. Follow-through on screening in

Delaware has shown that most early diagnoses have resulted in bracing. Due to this early detection program, operative procedures with spinal rods are almost nonexistent there today.

Some educational materials, including films for potential screeners, have been developed for schools and parents to identify and explain

It has been suggested that this be part of the recommended screening procedures afforded each pupil in the age group of 10 to 13.

scoliosis. Interested physicians may write the Scoliosis Research Society, 430 N. Michigan Avenue, Room 900, Chicago, 60611, or the Scoliosis Institute, in care of Mount Sinai Hospital Medical Center, California Avenue at 15th Street, Chicago 60608. The Scoliosis Research Society of the American Academy of Orthopedic Surgeons has available a slide sound presentation and screening program handbook for physicians and other professionals who would be involved in the actual treatment process. Various materials have been sent to members of the Academy and soon pediatricians and family physicians will be alerted to the need for early intervention in scoliotic children.

The Illinois State Medical Society hopes to encourage increased physician awareness in this area. Several groups are working on the problem, and many educational approaches are being developed. Board of Trustees action has permitted ISMS to encourage the Illinois Office of Education to include scoliosis screening as a part of the training for school nurses and physical education instructors.

It has been suggested that scoliosis be placed among the recommended screening procedures given each pupil in the age group of 10 to 13, roughly equivalent to grades five through eight. Some school boards may be reluctant to comply because it is not mandated. Physicians might wish to contact their local school superintendents and boards of education to encourage screening. In addition, the ISMS Auxiliary might bring these comments to their local school boards.

Clearly, scoliosis is a problem best attacked at the grass-roots level. Strong support by local physicians can help many children. ◀

RAO

Chicago El crash leaves 13 dead, 193 injured

February 4, 1977: Disaster Strikes!

The Associated Press wire photo (right) was taken on the night of one of the largest disasters in Illinois history. The horror of that night was among many incidents prompting increased attention to community support systems.

The State of Illinois Emergency Services and Disaster Agency compiles an annual listing of incidents which require state aid. Their data justify the statement that "No community is immune."

The ESDA listed a total of 1465 disasters between January 1, 1972 and September 30, 1977. These included "the greatest flood on the upper Mississippi in 200 years," according to Deputy Director and Operations Officer Robert S. Ritz, Jr., as well as natural and mechanical catastrophes touching every corner of the state.



Wide World Photos

was essential. Growing awareness of the need for support system preparedness has prompted disaster rehearsals such as that chronicled on the following pages.

Their listing found 79 major floods, 63 aircraft emergencies, 92 major highway accidents, 56 explosions, 83 major fires, 196 hazardous chemical warnings, 145 tornadoes, 51 peacetime rad-

In many instances, rapid medical aid

Montrose Harbor explosion leaves 180 injured

August 31, 1977: Disaster Rehearsal Prepares

CHICAGO—The city police and fire departments joined the Red Cross, CTA, Coast Guard and medical staff



Victims of the 1977 annual disaster rehearsal are treated by fire department, police and medical personnel for

curion cruise liner had exploded in Montrose Harbor and 180 passengers were scattered on the shore.

Precisely two minutes after the alarm sounded, Chicago Fire Department equipment was on the scene. Triage units were set up and medical teams moved rapidly across the field giving first aid and tagging victims for litter bearer transport. Policemen held off barge traffic and cleared traffic for ambulances. Chicago Fire Department Chief Medical Director Joseph Cari, was assigning medical teams. A fire marshal and Red Cross volunteer stood at the ambulance dispatch post. Fire Department litter bearers were transporting victims from Triage Unit 1.

At 10:19, exactly ten minutes after total chaos had erupted, the first ambulance left with dispatch orders.

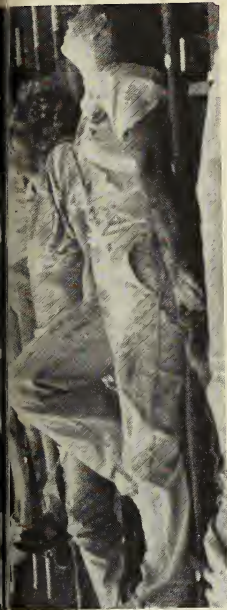
Vehicles from the Metropolitan Ambulance Association began to arrive six minutes later. The last equipment—a Coast Guard helicopter—landed at 10:45 a.m.

IMJ Perspective: A

The disaster this morning in Montrose Harbor brought a message to north Chicagoans: Relax. We can handle it.

It's clear that community residents have terrific odds for walking out of a horrible catastrophe alive. And minimally damaged.

A deserted beach suddenly flooded with 180 panicked, critically wounded persons, was almost instantly occupied with life-saving teams. The police department provided security and patrol cars, which would have been used for transport in a genuine emergency. The fire department carried 3 engines, 3



against the inevitable.

Preparation

Each participating hospital provided 20 victims, aged 16-60, largely culled from nursing and medical student staff. Victims assembled at their home hospitals and were transported to the site for moulage.

At 8:30 a.m., Frances Schmidt, R.N., from Forkosh Hospital, initiated moulage preparation at the scene. *(Continued on page 424)*

A reassurance for the future

and bulkier materials. As medical teams arrive at the scene, they take a triage bag from the van at dispatch site before entering the field.

Commissioner Albright estimated that the fire department supplied about 12 paramedics and 25-30 litter bearers for the disaster. The Coast Guard supplied a helicopter and scuba team. The Red Cross had personnel with their van on the site, as well as in each hospital. Metropolitan ambulance companies volunteered their services. The Chicago Transit Authority supplied a bus for the walking wounded. And the *(Continued on page 426)*

was having her baby. There were people dangling from trees. It was real enough to be scary.

"The fire department and police were amazing. They were completely systematic and calm. The people must have been briefed in advance about their injuries because the doctors would say 'Can you see my hand?' and one would scream 'No, I can't see' and the next, 'Yes, but my side hurts.'"

Teams cite many benefits

Representatives from each participant group in the 1977 disaster rehearsal met to critique performance this afternoon. The impartial observers enlisted by the Chicago Hospital Council for each hospital as well as coordinating participants from each agency on site were included. Robert C. Hamilton, M.D., a core planner and orthopedic surgeon from St. Joseph's Hospital, and James Petru, Ph.D., executive director of the North Side Commission on Health Planning, summarized their findings.

The disaster rehearsal has two components. Its primary purpose is evaluation of in-hospital preparedness. The secondary goal is "greasing the wheels": aiding coordination between diverse agencies for optimal on-scene efficiency.

"An internal hospital disaster plan is meaningful to the hospital itself," Hamilton said. "But in large scale planning that coordinates volunteers, moulage, communication systems, mechanical arrangements and interagency liaison, the learning experience is particularly significant. And the response *(Continued on page 425)*



Disaster rehearsal

(Continued from page 423)

tic molds of internal organs were attached to appropriate parts of bodies, plastic wounds from burns and cuts were secured in place and evidence of bleeding or bruising supplied. At 10:09 a.m., when the alarm sounded, the victims were in their places. The explosion had thrown some on the beach, some in trees and still others in the grass.

The first equipment arrived two minutes later. Within ten minutes the first victim was enroute to the hospital.

Red Cross and city personnel organized four triage units. The Chicago Fire Department 472 van brought medical supplies and triage materials. Four medical teams, each including two physicians, a nurse and a paramedic, moved quickly through the area. First aid was administered as the teams placed each victim in a crisis category.

Category 3 victims—the walking wounded—included those requiring non-emergency medical care. They would be carried by CTA bus to appropriate receiving hospitals. A Category 2 designation indicated emergency treatment, and Category 1 cases were life threatening. These were the first to go. Category 0 victims were pronounced dead by attending physicians.

I.D. System

Color coded tags with international symbols were attached to each victim. The symbols identified, numbered and categorized victims for triage. The tags are perforated, and medical teams detached the inapplicable categories for quick identification (see cover).

Doctor Cari maintained the medical command post, dispatching medical teams to specific areas of the site for triage. Litter bearers followed to read tags and transport victims to triage sites.

Ambulances arrived to carry Category 1 victims from triage site to dispatch. The dispatch area was manned by a fire marshal and a Red Cross volunteer. The Red Cross volunteer maintained radio contact with all participant hospitals, monitoring the patient load and, together with the fire marshal, determined where patients would be sent.

The ambulances roared off, their screaming sirens adding to the general chaos, toward Lake Shore Drive. Once they joined city traffic the sirens were silenced and ambulances observed speed limits.

At each hospital, Red Cross volunteers immediately met victims and obtained identifying information. (In a real disaster the Red Cross maintains the official list of victims. They first notify the families and then release information to the public.)

An impartial observer is stationed in each emergency room to evaluate staff response. According to James Petru, Ph.D., executive director of the North Side Commission on Health Planning, their evaluations consider such factors as security, presence of adequate medical personnel, emergency room facilities and the level of confusion. Their findings were shared at a general critique session later in the day.

The hospitals have no way to know how many victims they will receive. "They'd love to know," Petru said, "but in an actual disaster they can't. In an actual disaster we can't say that 38 patients will go to hospital Y and 52 patients will go to hospital X." They must prepare for a deluge.



Teams cite benefits

(Continued from page 423)

to the El crash in February pointed out just that."

"The primary aim," Petru said, "is to maintain realism as much as possible, but not to uphold realism before the value of goals to be achieved in terms of each institution. Somewhere in the middle we continually re-evaluate and draw a new line between the two."

Most of the planning takes place at individual hospitals, dovetailing with six interagency meetings commencing six weeks before the rehearsal. Dr. Hamilton was an active participant in 1975, and he noted progress.

"Everything went very much as planned," he said. "No hospital was overloaded and none had to turn away victims. The individual hospitals were able to handle it, and the rehearsal helped them to discover any defects in their disaster plans. Basically, everyone was satisfied that plans were suitable and people could get immediate transportation to a hospital for definitive care."

Required Patient Load

The critique found that what problems existed related to the fact that a great many victims are needed to place significant strain on each emergency room. Hospital emergency capacity is a predetermined quotient, and the rehearsal is designed to place maximum strain on each emergency room without sacrificing quality care.

The on-site problems, according to Dr. Hamilton, were mainly mechanical. Victims covered an area about 75% of a city block, and there were difficulties in transporting the victims to central triage sites.

"If the optimum number of patients were less," Dr. Hamilton said, "it would be easier at the scene. But the primary goal of in-hospital evaluation requires even more victims for the number of participant hospitals."

Transport for so many victims requires full ambulance, fire department and police support. Relegating full support for a rehearsal would place other areas of the community in jeopardy. For this reason, city agencies supply only about 50% of the personnel and equipment which would be used in a real disaster. In a rehearsal, therefore, transport delays are inevitable.

"In addition to the fire department surgeon, we may, in the future, designate one or two senior medical officers to deal directly with patients," Dr. Hamilton said. "It's also been sug-

gested that we divide the victims in two groups. The first would be triaged at the site as usual. The second group would be transported directly by bus to increase the number of victims to be treated. Thus, the transportation problem would be obviated without decreasing the number of patients at the hospitals."

Dr. Hamilton added that the American College of Surgeons Chicago Commission on Trauma may join the force next year. This would bring certain physicians with triage experience to work with the triage teams, and release non-trauma oriented doctors to treat patients at the hospitals, where their skills are best utilized.

A revised communications system may also be



in the offing. Presently, Chief Medical Director Cari sounds the Plan 3 alert through the Chicago Fire Department central office, which notifies all other parties. Communication from that point is maintained via Red Cross radio, from on-scene dispatch volunteer to the volunteers at each hospital. The volunteers determine the patient load at each hospital. It was noted that in February (during the Chicago El crash) some ambulances were rerouted from overcrowded emergency rooms. That was not a problem in the drill, but it has been suggested that hospitals could benefit from a more sophisticated network.

Another hurdle overcome with this drill was that of isolating "victims" from genuine patients. "In the past," Dr. Hamilton said, "hospital personnel and patients did become upset at the victims' appearance. This year, actual patients were

removed from the area just as they would be in a real disaster."

Learning Experience

"It's never absolutely perfect," Petru concluded. "The purpose for the foreseeable future will be to educate and not to test. If it were perfect, we wouldn't learn anything."

"The critique was really constructive. Individuals gave views of strengths and weaknesses both on site and at the hospitals. It was determined that most hospitals had at least adequate facilities—and several were exemplary."

Both Dr. Hamilton and Petru stressed the importance of disaster rehearsal. "No community is immune," Dr. Hamilton said. "Our experience in Chicago shows that the mechanics of disaster response require that every community become involved as an educational experience."

Dr. Hamilton discussed disparate challenges for communities within the state. The Chicago area is probably the most easily mobilized, because of its vast core of municipal agencies. Downstate rural areas shouldn't experience grave difficulties. The Chicago suburbs, however, have a genuine organizational challenge, coordinating not only hospitals but also separate fire and police departments.

Doctor Hamilton noted that ISMS might be able to help in this process, and will suggest to the Society that investigation should be made toward that end. Communities whose disaster capabilities have not been tested or are not sophisticated might glean some understanding from experiences around the state, and take initial steps toward some of their own.



IMJ perspective

(Continued from page 423)

Salvation Army refreshment van was on the scene.

Medical teams from St. Joseph, Columbus, Louis A. Weiss Memorial, Belmont and Ravenswood Hospitals were present. Six more area receiving hospitals were designated. And the six remaining hospital-members of the Chicago North Side Commission on Health Planning were placed on Alert—ready to convert for emergency treatment at a moment's notice.

The Planners

The Chicago North Side Commission on Health Planning is a voluntary association of 17 Chicago hospitals. According to James Petru, Ph.D., executive director, "the Commission represents an evolutionary, progressive and voluntary approach to the continual reassessment of health care needs in a shared community through the most efficient and cost effective means possible." The annual disaster is one project designed to meet this goal. The Commission is funded by dues from member hospitals and staffed by representatives of each.

This was the fifth annual rehearsal, Petru said, and it has two purposes. First, it is designed to allow each hospital to evaluate and revise dis-



aster capabilities. Secondly, it facilitates optimal cooperation among the service personnel. The "explosion" demonstrated a highly developed level of expertise in both areas.

Robert C. Hamilton, M.D., is an orthopedic surgeon from St. Joseph's Hospital. Dr. Hamilton participated in the 1975 disaster and served as a core planner for the explosion this year.

Doctor Hamilton pointed out that the Red Cross is an unsung hero in these projects. Their staff provided radio contact with receiving hospitals, monitoring patient loads at each and alerting them to the condition of victims enroute. The patient log, showing condition and receiving hospital for each victim, is maintained by Red Cross volunteers, who notify families and are the official source for public inquiries. It was the volunteers' log that determined the receiving hospital in each case, and assured that no emergency room was overburdened.

Salvation Army volunteers were also widely lauded. They arrived early, Dr. Hamilton said, to serve breakfast to victims while cosmetics were applied, and later served lunch at each receiving hospital.

Fire and police personnel play a dual role, Dr. Hamilton said, both as litter bearers and paramedics. The ratio of patients to medical personnel (physicians, nurses and fire department paramedics) was about 3/1 on the site. This represents about 50% of the support allocated by each agency for a genuine disaster.

The U.S. Coast Guard participated for the first time this year, providing a helicopter, three boats and a scuba team. They asked to join the effort, Petru said, "in order to find what kind of communication exists between them and municipal agencies."

State Requirements

The Joint Commission on Accreditation of Hospitals (JCAH) requires at least one community drill each year, in addition to 12 internal drills. The disaster network is defined by the Illinois Department of Public Health Emergency Services Disaster Agency.

IDPH has a tripartite categorization for hospital emergency rooms. Comprehensive hospitals maintain at least one physician in addition to laboratory, X-ray and similar facilities around the clock. Physicians in all major and some subspecialties are available within minutes. All category 1 triage victims must be sent to comprehensive hospitals.

Basic emergency rooms also staff a physician

at all times, but on-call specialists are limited to medicine, surgery, pediatrics and maternity. The ancillary facilities may be on 24-hour duty, but the basic hospital requirement demands only that they remain on-call.

Standby emergency rooms have minimal requirements. A registered nurse in the hospital must be available, and a physician is always on-call.

Psychiatric hospitals participated in the disaster for the first time this year. While not emergency oriented, they do have physicians on staff. One participant psychiatric facility treated rehearsal victims in the employee cafeteria until transfer was feasible.

The explosion involved 5 comprehensive, 2 basic, 8 standby and 2 psychiatric facility emergency rooms.

Status Report

Dr. Hamilton participated in the 1975 rehearsal, and noted progress this year. "The medical teams are more prompt and efficient. Generally, there's better coordination. It just seems that people know a little bit more what they are doing."

The 1977 disaster rehearsal is over. Six weeks of planning produced credible chaos. Five years of training produced a coordinated, professional response. In less than 90 minutes, victims of a major explosion in Montrose Harbor were treated with approximately 50% of the personnel and equipment for a Plan 3 disaster. In 3½ hours, all survivors had been treated in hospital emergency rooms, X-ray'd, blood-tested, and, in some cases, assigned hospital beds.

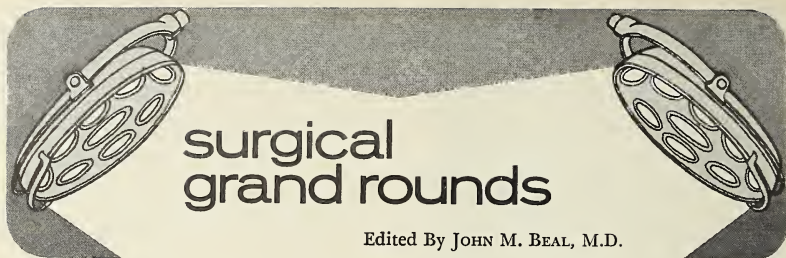
Relax. They can handle it.

The Illinois State Medical Society Policy Manual makes the following statement with regard to emergency preparedness:

Disaster Control

Any disaster creates an obvious need for trained personnel to aid the sick and injured. Local medical societies should cooperate to provide medical self-help programs. County societies should provide training for their membership in the treatment of mass casualties, radiological casualties and in the organization, operation and maintenance of emergency hospitals.

Photographs for this article and cover by Marc Simon and Richard A. Ott. Stories by Mariann E. McGuire.



Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of March 15, 1977.

Case Report:

Thymic Disease

Dr. Royce Larsen: A 22-year-old white woman was in good health until summer of 1975, when she developed generalized fatigue, difficulty in swallowing and breathing, and eyelid droop. A diagnosis of myasthenia gravis was made. She was treated with Mestanon® and Prednisone®.

Previous operations consisted of T & A in childhood and a triple arthrodesis in 1975 for a congenital deformity. Physical examination found a well developed, well nourished white female with cushionoid facies. Head and neck, cardiovascular and chest examination was within normal limits. Neurological examination showed bilateral ptosis and decreased masseter strength (graded as 4.0 over 5), which was symmetrical. Blood count, reflexes, urinalysis, chest X-ray, electrocardiogram and pulmonary function tests were within normal limits.

The large doses of medications produced nausea, vomiting, cramping and decreased appetite. Patient showed some evidence of weight gain and variable to poor response. The patient submitted to thymectomy eight months later.

The second patient was a 39-year-old white man with a diagnosis of myasthenia gravis, established one year before admission. His symptoms consisted of ptosis, increased weakness unrelieved with rest, diplopia, upper extremity

weakness, dyspnea and repeated upper respiratory tract infections. He was treated with Mestanon® and Prednisone®.

Review of systems was essentially noncontributory. Appendectomy had been performed 10 years earlier and a T & A in childhood. Physical exam found head, neck, cardiovascular and chest examinations within normal limits. Neurological examination showed decreased head control, nystagmus to the right with lateral gaze. There was a weakness of the right lateral rectus muscle, easy tongue fatigue and right ptosis with a furrowed forehead. His muscle strength was graded 3 out of 5 proximally and 5 out of 5 distally. Chest X-ray showed an anterior mediastinal mass. Pulmonary function showed a vital capacity of 69%. Thymectomy was performed.

Dr. Thomas Egan: The chest radiograph of the second patient showed a peculiar configuration of the right mediastinal border, which should be a smooth line. (Figure 1) The lateral radiograph shows some fullness and increase of soft tissue density in the anterior mediastinum projected over the heart. Calcium was not seen in this mass. Tomograms were obtained, both AP and lateral projection, and a mass was demonstrated in the anterior mediastinum extending over to the right. The lateral tomogram shows a lesion without calcification which measures ap-

proximately 7 x 6 cm, with sharply demarcated margins. (Figure 2) The lesion is compatible with a clinical diagnosis of thymoma. The differential diagnoses would include dermoid cyst, teratoma, and substernal thyroid.

Dr. Royce Larsen: At the time of operation, a thymoma was found with two pericardial implants adjacent to the tumor.

Pertinent History

Dr. Robert Gordon: These two cases illustrate the range of problems in myasthenia gravis, the first a patient with a normal thymus and the second a patient with a malignant thymoma. Among adults, thymoma is the tumor most commonly found in the anterior mediastinum and the second most common tumor in the entire mediastinum. Blalock (1939) first described the relation of thymus to myasthenia gravis and investigated this relationship. Myasthenia gravis has been reported in patients with thymoma, varying between 10 and 50%. Thymomas are seen in patients with myasthenia gravis in approximately 15% of cases.

There are two current theories. One suggests an immune dysfunction of some type, and the other a substance released by the thymus gland which affects the neuromuscular junction.

Approximately 43% of thymomas are located in the upper third of the mediastinum. Fifty percent are in the middle third and 7% in the lower third. Thymic tissues may have an ectopic location. The most common site is cervical, but it may also be found along the left main stem bronchus, the posterior mediastinum, hilar and even intrapulmonary sites. This is important during myasthenia gravis surgery, because one must remove all adipose tissue from phrenic nerve to phrenic nerve and from the cervical area to the diaphragm, so that no ectopic thymic tissue remains.

Investigation before operation includes chest X-rays with lateral tomograms and, in some centers, thymic venography.

Review of thymic region tumors has revealed that approximately one-half of these are true thymomas. The remainder are found to be malignant lymphomas, primary or secondary carcinomas or hemangiomas. Patients with thymoma are usually older than patients operated on for myasthenia gravis without thymoma, and this influences prognosis. The results of thymectomy in myasthenia gravis are much better in patients without thymoma. In one series of 37 patients with normal thymus glands, 34 were improved after thymectomy. However, only 8 of 13 pa-



Figure 1

Chest film demonstrates abnormal contour of the right border of the mediastinum, suggestive of a mass (case 2).

tients with thymomas benefitted from surgical treatment.

Histologically, thymic tumors have lymphoid and epitheloid elements. The histological type does not reflect prognosis. During surgery one can usually differentiate benign from malignant thymomas. The lesion is malignant if it invades surrounding structures and/or implants. However, it is often difficult to determine whether the thymoma is benign or malignant on histologic study. Benign tumors are usually well encapsulated with some nodularity and sometimes calcification. Malignant lesions show infiltration at the margins, with vague borders and sometimes necrosis. If the patient improves immediately postoperatively, permanent or extended remission is likely. However, sometimes the patient requires up to one year after surgery before showing improvement.

Indications for Surgery

The two major indications for operation in myasthenia gravis are (1) uncontrolled symptoms despite large doses of medication, especially in young people with a short duration of disease, and (2) the suspicion of a thymoma. When operation is performed, one should avoid anticholinergic medications for 3 to 5 days before and after operation. Both sternal splitting incisions and cervical incisions are used. Most favor the sternal splitting incision because it facilitates



Figure 2

Tomograms (case 2) demonstrate sharply demarcated anterior mediastinal mass.

the necessary removal of all ectopic thymic tissue. Those who favor the cervical incision have emphasized that this approach is associated with fewer respiratory problems and that most of the ectopic tissue is found in the cervical area.

The most common cause of postoperative death is ventilatory insufficiency. For this reason, intense respiratory treatment is necessary both pre- and postoperatively. In both of these patients, presurgical respiratory consultation was obtained. Postoperatively, these patients can develop an anticholinergic myasthenia gravis crisis if these drugs are given. These patients are often very sensitive to their preoperative medications. In addition, they can develop weakness secondary to antibiotics. Indications for tracheostomy in these patients include a history of previous myasthenic crises, or respiratory problems, oropharyngeal problems, or a vital capacity preoperatively of less than 200 cc.

There are several other diseases detected in patients with thymoma. These include cytopenias, carcinoma and hypogammaglobulinemia and other disease entities. These obviously affect the patients' prognosis. In patients without symptoms, the five-year survival is approximately 61% and in patients who have symptoms associated with their thymic disease, the five-year survival rate is 30%. The mortality second to myasthenia gravis is much greater than the mortality second

to the tumor itself.

Further Clinical Background

Dr. Howard Simon: Myasthenia is a very interesting disorder and much must be learned about oncogenesis and autoimmune disease in general before the etiology is determined. Significantly, this disease has a bimodal distribution. It is easy to remember that myasthenia is a disease of young women and old men. Perhaps now, in 1977, we can say that the HLA type of the two different groups underlies the distinction, but it is a bimodal disease.

Clinically, myasthenia is most often confused with neurasthenia, because depressed people feel fatigued and go from doctor to doctor, from year to year, and may finally get a spurious diagnosis of myasthenia. Ocular involvement is prerequisite to myasthenia diagnosis. Fatigue is just fatigue unless there is involvement of the eyes, either ptosis or double vision. Of course, the major characteristic is the diurnal variation and it can be dramatic. Not only are myasthenics worse in the evening than they are in the morning, but I have had patients get the appetizer down and choke on dessert, due to fatigability of the bulbar musculature. The eye findings are important. Not only are they weak, but they characteristically fatigue; what starts as normal strength can rapidly be shown to be suboptimal.

The diagnosis is not tenable without a positive tensilon test. Tensilon is edrophonium hydrochloride, a rapidly acting anticholinesterase which is injected intravenously. Ptosis is a good objective parameter. Patients want to get better and Tensilon tests have to be controlled with saline. Another important point is that if you have to argue whether the patient got better or not, the answer is that he did not. The findings have to be striking—striking improvement in strength. It is most dramatic to see patients who can't talk, can hardly see, can't get off a bed, jump up and embrace the doctor for his magical powers within seconds of getting the Tensilon. Unfortunately, the Tensilon wears off in a matter of minutes, so it represents only a diagnostic test. The other point to understand is the management of these people. With their anticholinesterase medication, people forever get in trouble because they have tried to adjust the medication without Tensilon testing prior to changing the dose. We have to demonstrate before each dose that the patient needs the medication, rather than just guessing that he is better. The problem is that too much medicine simulates the weakness

of myasthenia—the old cholinergic versus myasthenic crisis. The respirator represents current treatment for crisis. If the myasthenic patient comes in weak—either he has had too much medication or not enough. If too much, improvement comes when medication is stopped. The idea is to do nothing. If the patient is overdosed, placing him on the respirator lets the drug wash out and he gets better. If patient is myasthenic and weak, nothing can happen as long as the respirations are supported.

Peripheral Issues

A couple of other sort of anecdotal comments about the clinical picture—all muscle poisons make myasthenia worse. The commonly used ones are Pronestab® or quinidine. I remember very well a patient who was doing great until the summertime when he began drinking gin and tonics. I thought little of it, until the quinine in the tonic made his myasthenia go haywire. The other group of drugs that do this are the antibiotics. If a drug company wants to see if a compound has antibiotic properties, they throw it into a nerve muscle preparation. Muscle suppression indicates possible antibiotic potential. Clinically, the colistins and polymyxins can suppress these patients very badly. Neomycin and streptomycin also have been implicated.

The diseases associated with myasthenia gravis were mentioned by Doctor Gordon. I must emphasize the higher incidence of carcinoma in a myasthenic population. The decreased incidence of cancer after a thymectomy is done may provide food for thought for surgeons. If you look at risk per patient years, there is rather dramatic benefit in the myasthenic group of patients who have been thymectomized. The relationship with lupus is well appreciated and easily understood in terms of the autoimmunity. It is also true that myasthenia is related to thyroid disease, either to hyperthyroidism or hypothyroidism. Perhaps the relationship is founded in the common derivation of thymus and thyroid from the branchial arches.

Causal theories have been debated extensively. It has been said that there probably is not another human disease about which we know so much without knowing the precise cause. Formerly, the question was whether the problem in myasthenia was a presynaptic or postsynaptic deficit. It was thought that either the patient did not have enough acetylcholine or that a normal amount of acetylcholine just didn't do the

job for one reason or the other. An even earlier theory hypothesized a curare-like substance in the blood stream that paralyzed the patient.

The notion of something circulating was demonstrated by juvenile myasthenia, an interesting condition. A small percentage of myasthenic mothers will give birth to a child afflicted with myasthenia that wears away in a few days. If it is recognized at the time of birth and the child is supported, he "outgrows" his myasthenia in a week or two, not to be afflicted again throughout his life. So there likely was some type of factor coming across the placenta.

A lot of research in the last few years can be summed up in one circumstance. It is now known that if you take immunoglobulin G from myasthenic patients and inject it into a mouse, the mouse becomes myasthenic. The immunoglobulin G is the culprit in myasthenic patients. The problem is postsynaptic and is due to autoimmunity. An immunologic factor produces the disease in these people.

Further Questions

Having solved that, the current controversy is between the T-cell people and the B-cell people. The lymphocyte and immuno mechanism advocates note that the lymphocytes of myasthenic patients are active and will respond to acetylcholine receptor. Further, they pick up thymidine and all the various immunological parameters are increased, that is, the lymphocytes show increased activity in myasthenic patients. One would anticipate that if you figure the thymus has something to do with this, the T-cells are somehow involved. T-cells relate to lymphocytes, which implies a second relationship. It is probably true that the thymus is orchestrating various types of autoimmunity responses. Thymocytes, lymphocytes and immunoglobulin G are all related to the production of this disease, but exactly how is not known.

There are some major questions that are not resolved, even though we know there is an antibody. What initiates antibody production? Why is it that myasthenia is characterized by involvement of only some of the muscles? How can there be an attack on the right deltoid and not the left? That is characteristic of myasthenia. In fact, it is even more complicated. Some muscles can be overdosed with Mestanon while others are underdosed. Why is this?

We do not understand what the T-cells are doing. T-cells produce antibody, but their precise activities are unknown. Treatment of this

disorder can really be broken down into three separate categories. The first and the first known was anticholinesterase medication. There are many little tricks. It is still useful in the myasthenic patient; we use Mestanon® all the time and it works pretty well, although it surely is not curative. The second thing to come along was the advent of corticosteroids. Again, there was much debate. The initial reports back in the late 40's and early 50's indicated that steroids paralyzed myasthenic patients and for years they were thought to be contraindicated. In the early 60's, it was found, really by serendipity, that if you give ACTH, not cortisone, to a myasthenic patient, two things happen. First, he gets paralyzed, automatically, predictably, 100 percent paralyzed within four or five days and the patient has to be supported with a respirator. Once he survives that, he has an increased chance of going into remission and 50 to 70% would do that. Unfortunately, the remissions were short lived and the course of ACTH would have to be repeated. This was a veritable cornerstone of drug therapy for awhile. Only within the last three or four years, did we learn that alternate day prednisone, not ACTH, has an effect upon the disease. It turns out that regular steroids do not paralyze the patient, but bring on a remission rather quickly. Again 50 to 70% can be put into remission by using high dose alternate day steroids.

The third aspect of therapy is thymectomy. Thymectomy, too, has been the seat of raging controversy among doctors who handle a lot of myasthenic patients. It was very interesting that until the late 60's there was no controlled evidence that it helped at all. That was rectified in part by a Massachusetts General study and a Mt. Sinai study showing definite improvement in the thymectomized group of patients. The current enthusiasm for thymectomy is based upon recent long term follow-up studies which indicate that a remission can be induced, not up to a year but up to six or seven years after the thymus gland is removed. This is very interesting, but is perhaps explained by such factors as clones of T-cells resting outside the thymus. Nonetheless, it is a fact that a late remission is seen in myasthenic patients who have had their thymus out. To reemphasize what Doctor Gordon said, we are not talking about patients with thymoma, but about patients with nothing visible on the anterior mediastinum who have chest surgery to remove whatever tissue is found. Histologically, it looks like a hyperplastic thymus gland. In this group of patients the incidence of remission is

about 90% up to six or seven years later. This explains current enthusiasm for thymus removal. It is interesting that studies of the transcervical approach find the same remission rate. Despite all difficulties, a series of 400 thymectomies found no difference in remission between going transcervical and just fishing for the gland or opening the chest.

Within the last couple of weeks something new was discovered in terms of the thymus gland. It appears that thymomas not visible on X-ray can be picked up with Gallium scans. Someone reports seven or eight cases where the tumor was not visible but was picked up with the Gallium scans.

Doctor Gordon talked about the thymoma itself as an indication for thymectomy. I agree with that, myasthenia or no myasthenia; but also offer another bit of clinical information to ponder. There are now 36 reported cases in the literature of patients who have had a thymoma removed, never had myasthenia and then subsequently developed the disease after the thymoma was taken out. That absolutely defies explanation.

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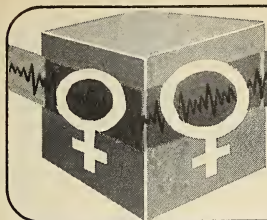
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MRS. EUGENE VICKERY, Editor



KEY LINES:

By BETTY SZEWCZYK, PRESIDENT, ISMSA

Fall Checkup

Membership—like life—is what you make it. And district meetings across the state have made ISMSA membership both exciting and fulfilling these past few weeks. Councilors have maintained the "Teach the Children" theme while adding a bit of something just for the adults.

September 15 proved to be a beautiful fall day in Rockford, Illinois. Martha Leonard, District 12 Councilor, and Winnebago auxiliaries decorated the Mauh-Nah-Tee-See County Club with clever dried-flower door arrangements that were later given to new members attending the session. County representatives were introduced and Winnebago County President Louise Modir addressed the new members. State President Betty explained her infatuation with the "key" and went on to tie it all together for a "keystone" address. (A keystone is the central or topmost stone that holds the other pieces together.) President-elect Jane Klaren presented a case for militancy toward TV violence. We must constantly be aware of the intrusion of TV into our homes and teach our children to watch it with discrimination and care. Carol Cratty stressed prevention in her talk on "Child Abuse." Local humorist Mrs. Monita Voellinger entertained us at lunch and then we got right back to serious business with a lesson by Mr. Mike Vascellaro, Director of Curriculum for Rockford Public Schools, who discussed "The Role of the Parent in Educating Children." He noted, surprisingly, that a child

spends only 3% of his time in school!

We then moved to Mt. Vernon for the District 9 and 10 meeting on September 20. District 9 Councilor Helene Boba gave a warm welcome to Councilor Ginny Gregowicz and the District 10 people who came to Jefferson-Hamilton County for the meeting. County Presidents reported, as did the State President and President-elect. Mrs. Margaret Smith, school nurse for the Mt. Vernon Grammar and Junior High Schools, then described the problems she sees as a nurse, how she copes with them and health teaching available to students. After lunch, we traveled to the Mitchell Museum where Mrs. Susan Kolojeski of Carbondale gave a historical slide presentation on the extraordinary art of quilt making in Southern Illinois.

The month was quickly slipping away, as we traveled to the historical city of Quincy. We were enthralled by many beautiful old homes, especially on "Maine" Street. There we found Warfield House, former home of William S. Warfield, well known Quincy merchant and banker and now a community center. It was an interesting and exquisite background for our meeting, which was

hosted by Jewel Gwaltney, Adams County President, for District 4 Councilor Meg Koivun and District 6 Councilor Meinard Kooiker. In addition to the district and county reports, Laura Ragar, State Family Health Chairman, presented her ideas for an auxiliary approach to family health this year, with special emphasis on the teen-ager and alcohol and drug abuse. She suggested that alternatives be sought for these young adults to supply meaningful ways for them to fill their time. A visit by Mrs. William Walker, (Pat) AMAA Regional Vice President of Membership, was a very special privilege. Mrs. Walker traveled through the torrential waters from Springfield, Missouri, presented her views about membership and what it can do for you as an individual, as well as what it can do for the image of medicine. Pat told us about the new idea of "Marketing Membership"—you get one other person to join—doesn't sound very difficult, does it? It would simply double our membership! The day held yet more interest—Dr. James Cravens, pediatrician from Quincy, gave us a detailed study on child abuse. Amazingly, there was still energy for a Historical Walking Tour along Maine Street and the surrounding areas!

A beautiful October day brought us to Cham-

paign for the District 5, 7 and 8 Meeting. District 8 Councilor Corinne Laidlaw did an outstanding job of hosting for Councilors Doris Miller and Helen Prentice. Corinne set up the meeting in the quaint Jumer's Castle Lodge and warmed it with dried flower arrangements to be sold for the benefit of AMAERF. The day included county, district and State President reports and a real "pep" talk by Rose David, State Chairman of Members-at-Large. Rose said that diligence and caring could bring the 600-plus prospective members-at-large into our fold. Dr. Dorothy Schultz, a neurologist and member of the ISMS "Panel for the Impaired Physician" discussed this new program to help the troubled physician. More information may be obtained by writing the ISMS office. Following lunch, Dr. Anthony Vattano, Associate Professor of Social Work at the University of Illinois presented "Relaxation Procedures for Coping with Stress and Anxiety." He warned that "we relax at our own risk" and, luckily, no one fell out of their chairs!

As County and District travels are briefly suspended, we look back with pleasure and a feeling of accomplishment, while anticipating the "Teach the Children" Fall Conference and meeting with Districts 1, 2, 3 and 11.

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report

Illinois Society
American Association of Medical Assistants

"The Thirteenth Person"

Drinking for enjoyment is socially and personally acceptable for twelve out of thirteen persons in the United States. The thirteenth person no longer enjoys drinking, nor is his drinking socially acceptable. His drinking is destructive to himself and harmful to others. Though he may know this, he cannot stop drinking. He is an alcoholic.

The Kankakee County Chapter of the American Association of Medical Assistants, Illinois Society, will present "The Thirteenth Person", a symposium on alcoholism on Sunday, November 20, 1977, at St. Mary's Hospital Auditorium, 145 S. Fourth, Kankakee, Illinois.

Alcoholism is a disease that does not respect age, sex, creed, race, wealth, occupation or education.

Did you know that alcoholism is considered by the Public Health Service to be the number 3 public health problem in the United States?

Did you know that only 3% of these alcoholics are on "skid row" and the other 97% are found in homes, offices and factories?

Dr. Reinhold Schuller, a member of the ISMS Committee on Alcoholism and Drug Dependence and a Kankakee County Chapter AAMA advisor, will discuss how the committee helps the impaired physician through the five stage treatment process: education of the nature of the impairment, individual counseling, rehabilitation as an outpatient or inpatient, re-entry into medical practice and ongoing maintenance therapy. This committee, a group of volunteer physicians, are committed to seek out those in need of aid and assist them through a physician-patient relation-

ship within the confines of absolute confidentiality.

James W. West, M.D., F.A.C.S., Co-Chairman of the ISMS Committee on Alcoholism and Drug Dependence, Chairman of the ISMS Panel for the Impaired Physician, and Assistant Professor, Department of Psychiatry at Presbyterian-St. Luke's Medical Center, will present "Alcoholism—The Disease".

"Alcoholism is an illness," said Dr. West. "The disease is not in the bottle, but in the person. One cannot produce an alcoholic by making him drink. Before he ever takes his first drink, predisposing factors have established the basis for his addiction." Dr. West will discuss the nature of the disease and the misconceptions about alcoholism.

Mr. Ben Thomas will show a film "Step Out of the Shadows" and will share with us his personal trauma of alcoholism, how it affected his life and those he loved, how he was able to re-

"The Thirteenth Person"
Sunday, November 20, 1977

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cover and has now dedicated his life to assisting others in their struggle against this disease.

Mr. Thomas was the first Executive Director of the South Suburban Council on Alcoholism, Harvey, Illinois, and is currently working with the Will County Courts, Silver Cross Hospital and St. Joseph's Hospital, both in Joliet and Silvis Grove at Manteno Mental Health Center, to screen and assist the alcoholic to recovery.

Mr. Robert J. Blattner, inpatient coordinator of the Alcoholism Treatment Center, Ingalls Memorial Hospital, Harvey, will present a general orientation of the philosophy of treatment at Ingalls Hospital for rehabilitating the alcoholic.

"During the rehabilitation phase," Mr. Blattner explained, "we emphasize the neuropsychological aspects of the disease of alcoholism with our patients. In order to properly diagnose neuropsychological disorders, we have developed a diagnostic and research service which incorporates the use of the Halsted Neuropsychological Test Battery."

Mr. Blattner will also discuss various treatment modalities which include group and individual therapy as well as family therapy and extensive involvement with the AA community.

A discussion by a panel consisting of a physician, social worker, priest, a non-practicing alcoholic and a rehabilitative expert will conclude the symposium on "The Thirteenth Person".

Application has been filed for consideration of awarding CEU's. We invite you to join us as we explore this chronic psycho-biological disease of alcoholism.

Registration begins at 8:45 a.m., and the program will begin at 9:00, concluding at 3:00 p.m. The registration fee, which includes luncheon, is \$8.00 for members and \$10.00 for non-members. Please make checks payable to AAMA, Kankakee County Chapter Symposium. Checks should be mailed, along with the form below, to Mrs. Mary Smith, Registration Chairman, c/o Dr. Tapendu Basu, 475 W. Merchant, Kankakee, IL 60901.

Viewbox

(Continued from page 398)



Figure 4

DIAGNOSIS: *Metastasis to the colon from a Ca of the stomach—*

Figure 1 demonstrates that the lumen of the stomach outlined by air is markedly narrowed and infiltrated. This suggests that the lesions which appear extrinsic in the sigmoid and splenic flexure are not arising from the colon. An upper GI study (Figure 4) revealed a typical linitis plastica which was confirmed surgically. The spread of neoplasms within the peritoneal cavity occurs by direct invasion, intraperitoneal seeding, embolic metastasis, and lymphatic spread. The lesion in the region of the splenic flexure is probably the result of direct extension along the gastrocolic ligament and the second lesion in the region of the sigmoid probably represents extension by intraperitoneal seeding. The important thing to remember is that information on films may be away from the direct area of interest and attention to them can result in a proper diagnosis.

Reference

Morton A. Meyers: *Dynamic Radiology of the Abdomen*, Springer-Verlag, pub., pp. 37.

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Rheumatology Rounds

L. F. Layfer, M.D., and J. V. Jones, M.D., Contributing Co-Editors

Unilateral Heel Pain in a File Clerk

A 59-year-old file clerk was seen for unilateral heel pain. Five months previously, she noted onset of a dull ache under her right heel, which became sharp and piercing when supporting weight. There was occasional radiation of the pain to the ankle. Walking became increasingly difficult and the pain interfered with her daily activities.

Except for occasional stiffness in her fingers, other joint complaints were absent. She denied a history of trauma to the foot, although she stood throughout the workday. Rheumatic history and review of systems were non-contributory.

On examination the feet revealed bilateral asymptomatic bunions. The toes were otherwise normal. There was a well defined area of tenderness over the medial aspect of the plantar surface of the right heel, just under the calcaneus. The left heel was non-tender to palpation. The achilles tendons were non-tender bilaterally, and ankle motions were normal. The hands revealed Heberdons and Bouchards nodes over several distal and proximal interphalangeal joints respectively. Other joints and a general physical examination were unrevealing.

Laboratory

Sedimentation rate was 10 mm/hr. Rheumatoid factor was absent from serum. An X-ray of the right foot (Fig. 1) revealed small calcifications at the insertion of the achilles tendon on the calcaneus, but was otherwise unremarkable.

Comment

Inflammation of the soft tissues under the calcaneus is a common cause of unilateral heel pain. It is typically found in elderly people whose atrophied calcaneal fat pad no longer effectively absorbs the burden of weight-bearing or in those whose occupation entails excessive standing or walking. The tissues become inflamed from recurrent stress and tender to touch. The subcalcaneal bursa, located on the medial side of the heel under the calcaneus, is often the inflamma-



Figure 1

Small calcifications are seen at the insertion of the achilles tendon. The calcaneus and soft tissues under it are normal.

tion site and gives rise to a local bursitis called a "policeman" or "soldiers" heel. More diffuse pain under the heel occurs from inflammation of the fibers of the plantar fascia near its insertion on the calcaneus. The distinction between such fasciitis and bursitis may be difficult. Diagnosis is made by tenderness to palpation on the plantar surface of the heel under the tip of the calcaneus and by absence of bone and joint changes on X-ray. Other causes of heel pain (Table 1) don't give the plantar tenderness so characteristic of this syndrome. Although usually related to stress, plantar fasciitis occurs in the rheumatoid variant diseases (Reiters, ankylosing spondylitis, psoriatic and enteropathic arthritis) and these should be considered when the characteristic pain occurs. Calcification in the plantar fascia forming a calcaneal spur can be seen in

Table 1

Plantar soft tissue—bursitis
fasciitis
Achilles tendon—tendonitis
bursitis
partial rupture
Subtalar joint—Osteoarthritis
rheumatoid arthritis
Calcaneus—fracture
tumor
infection
Referred pain—S1 radiculopathy
Childhood—calcaneal apophysitis
(Sevens syndrome)

both symptomatic and asymptomatic patients, and its pathologic significance is unclear.

Treatment is directed towards controlling the inflammation and alleviating the stress of weight-bearing. A soft heel pad inserted into the shoe will absorb some of the shock of walking. A hole may be cut in the pad corresponding to the area of maximum tenderness to remove weight in that area. Oral anti-inflammatory agents may be useful. A local injection of a lidocaine and steroid solution through the heel pad directly into the area of tenderness is most effective. This

may be repeated several times. Rarely, removal of a calcaneal spur may be necessary for recurrent disease.

Conclusion

Because of the well defined area of tenderness on the medial aspect of the heel pad, the patient was thought to have a subcalcaneal bursitis. A lidocaine and steroid solution was injected into the area of maximum tenderness with immediate relief of pain. A soft heel pad was constructed with part of its medial aspect removed to spare the bursa from weight bearing. Follow-up at one week and six months revealed the patient to be asymptomatic. ◀

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Richard A. Ott, Managing Editor

EKG

(Continued from page 393)

Answers: 1. C,D,E. 2. D.

The ECG rhythm strip shows a sinus rhythm with rates that vary slightly from 56 to 60 beats/minute. The fourth beat in the top line and the ninth beat in the bottom line are fusion beats that initiate a run of ventricular rhythm at a rate of 83 beats/minute. This is called an accelerated idioventricular rhythm. It occurs with atrioventricular dissociation and rates of 60 to 100 beats/minute, and is common in the setting of acute myocardial infarction. Frequently, the rhythm does not disturb the patient.

This represents an acceleration of a subsidiary pacemaker. Recent animal studies suggest that it is on a reentry physiological basis (B. J. Scherlag *et al.*: "Mechanisms of Ectopy due to Ischemia" in *THE CONDUCTION SYSTEM OF THE HEART* Weller, Lie, and Jause, eds., Lea and Febiger,

pub., Philadelphia, 1976). These workers were able to demonstrate a delay in conduction of up to 330 msec. in the ischemic zone, a finding consistent with a reentry mechanism. The slight lengthening of the RR cycle from 720 to 800 msec. between beats 5 and 6 in the top line is in keeping with this concept.

The treatment is careful observation, because more malignant rhythms can occur in these patients. If symptoms develop with this arrhythmia, i.e. chest pains or hypotension, atropine should be given intravenously. Digitalis intoxication ought to be considered (although not applicable in this case). Our patient had several short episodes of the rhythm that never required treatment, and had an otherwise uneventful recovery.

IMPAC

ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE

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It took 142 years - 1789 to 1931 - for our federal government to spend \$100 billion dollars. Thirty-one years later, in 1962, our government managed to spend \$100 billion in one year. It took only nine more years to get to the \$200 billion per year level, and three years later, in 1975, we went over the \$300 billion mark. That was 1975, but now, it's getting easy. This year, the federal government will spend over \$400 billion --- that's more than a billion dollars a day.

Each day, we read that a major portion of the federal dollar goes to health care --- that doctors are responsible for much of this billion dollar a day spending pattern. The result? --- lack of public confidence ... increased regulation ... increased paperwork ... increased personnel needs (to fill out the increased number of forms) ... and finally increased costs to be passed on to the public, which, in turn, raises the cost of health care one level higher. Where has this led? Presently to a federal proposal setting a cap on inpatient hospital revenues and giving the Secretary of HEW absolute control over expenditures for new equipment in both hospitals and private physicians' offices ...

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Something Is Missing



The dazzling array of scientific riches at the disposal of our profession can overwhelm even the most "up to date" physician. Echo cardiography, angiography, CAT scanning and other marvels all are highlighted at medical conventions. There's usually even an answer for the bewildered physician who mutters "what next?"

Educational sessions are presented in a demanding and brusque manner, often with exhibitors on hand to "peddle their wares." We are bombarded with detailed explanations of the latest technology and informed that even more unique developments are just around the corner. This is both humbling and uplifting. We are humbled because there is so much we don't know . . . and buoyed by the fact that we are part of a dedicated, highly technical profession.

Something is missing at these meetings. You don't hear much anymore about the patient—that individual whose life is dependent upon these modern technological miracles.

Our fascination with technology has dulled our perception of patients as fellow human beings. There is a link between this preoccupation with the mechanical and the erosion of public confidence in our profession. That confidence can be strengthened only if we make a concerted effort to reassure patients that we care about them as people . . . not merely as bundles of symptoms that can be translated into impressive statistical studies.

In medical schools and at hospital staff and other meetings, we must focus on human needs and sharpen our awareness of patients as fellow human beings. Otherwise, we face a loss that technology cannot replace: The loss of our patients' faith and trust.

A handwritten signature in cursive script that reads "George T. Wilkins, Jr.".

George T. Wilkins, Jr., M.D.

Doctor's News

PHYSICIANS IN THE NEWS—Charles Reed, M.D., Chicago, a clinical instructor in the department of preventive medicine at the University of Illinois has been named medical director of the Valley Outpost Clinic in Chicago. The clinic is a community health center affiliated with the University. . . . A Chicago physician, Eugene L. Derlacki, M.D., has been installed as president of the American Academy of Ophthalmology and Otolaryngology. Doctor Derlacki, a professor in the department of otolaryngology and maxillofacial surgery at Northwestern University Medical School, is senior attending physician at Northwestern Memorial Hospital.

GLAUCOMA CONGRESS SCHEDULED—The second international glaucoma congress will be held in conjunction with the 13th annual meeting of the American Society of Contemporary Ophthalmology from January 30 through February 3, 1978. The congress, which will meet January 28 and 29, is a clinical symposium shared by international experts in the field of glaucoma treatment and prevention. For further information about the congress or the annual meeting, please contact John Bellows, M.D., director, 6 North Michigan Avenue, Chicago 60602, (312) 236-4673.

CONGRATULATORY TELEGRAM—James H. Sammons, M.D., executive vice president of the American Medical Association, sent a telegram on September 27 to George T. Wilkins, M.D., ISMS president. The telegram noted that ISMS had already exceeded its 1976 dues-paying membership total. "Keep up the good work," the telegram reads in part, "Hope you can inspire others to do the same."

CLICHE CONDEMNED—Rep. Paul Simon, D-Ill., has joined 25 other members of the House and Senate in asking President Carter to reverse the conviction of Samuel Alexander Mudd, M.D., who set the broken leg of John Wilkes Booth after Lincoln's assassination.

"His name is mud" grew out of the conviction—under questionable circumstances—of a physician named Mudd. And those of us who have an interest in history, as well as interest in justice, believe that even though generations late, justice should be done to the Mudd family," the letter reads in part. ". . . Booth and his companion used false names, and Booth wore a disguise at the Mudd home," the letter continues. "Dr. Mudd treated the broken leg as any doctor would treat anyone who was suffering. . . . There is no evidence that Dr. Mudd committed any crime. His trial was unfair and illegal. We urge you to correct this 112-year-old injustice by declaring Dr. Mudd innocent."

R&E REVIEWS LICENSING—A blue-ribbon committee appointed by Gov. James R. Thompson and Joan G. Anderson, Director of the Illinois Department of Registration and Education, has undertaken an overall review of the Department's examination system. According to information from the Department's offices, the committee has indicated that it favors more public access to the state's examination and licensing procedures. They will consider whether tests for licensing of individuals in areas ranging from medicine to horse-shoeing are adequate and whether they should be practical, oral or written. Grading standards and the possibility of offering some tests in foreign languages will also be considered. The panel hopes to forward findings in March of 1978.

TRANSPLANT STATISTICS—A recent article in the "Journal of the American Medical Association" contained some interesting data on organ transplant survival.

About 338 persons have received heart transplants within the last ten years, the study found. Among them 77 are still alive—the longest survival recorded at 8.7 years after surgery. Liver transplants have also fared well, 47 persons of 307 surviving and one person living for 7.5 years.

Lung and pancreas transplants have not achieved such positive results. Of 37 lung and 55 pancreas transplants, none are still living. Donor lung recipients achieved a maximum life of 10 months, and pancreas recipients 4.2 years.

DIABETES STATISTICS—The Juvenile Diabetes Foundation, which gathers funds to support research into diabetic treatment, has released recent figures on what has been termed the third leading cause of death in the United States.

The Foundation estimates that 10 million Americans are afflicted by the disease to some extent, and that 600,000 will develop diabetes in the next year. Diabetes has been cited as a leading cause of blindness, heart attack, stroke, kidney failure, gangrene and nerve damage. Lost wages, disability and health care payments for diabetic treatment represent a \$5.3 billion national expenditure.

Further information about recent clinical findings and also the Juvenile Diabetes Foundation may be obtained by writing them at 23 East 26th Street, New York, New York 10010.

ISMS OFFERS HELP—Robert T. Fox, M.D., chairman of the ISMS Board of Trustees and George T. Wilkins, M.D., ISMS president, have sent a telegram to Illinois Gov. James R. Thompson, offering assistance in developing legislation which would permit the Illinois Department of Public Aid to suspend or terminate Medicaid providers proved guilty of fraud. The telegram was prompted by a recent Illinois Supreme Court ruling in the Bio-Medical Laboratories, Inc., case which found that the Public Aid Department lacks legislative authority to make such terminations or suspensions.

The telegram states:

"The court ruling will impair the ability of the Illinois Department of Public Aid to control fraud in the Medicaid program. In many respects, we believe the Department must bear responsibility for this outcome.

"For the past two years, Illinois State Medical Society has attempted to convince the Department that its Medicaid payment and audit rules and systems were ineffective and unfair. The Supreme Court has now declared them illegal. The regulations promulgated by the Department often violated basic rights of Medicaid patients and providers; often were applied retroactively; and caused enough harrassment to drive honest providers out of the program. Rules governing the program must effectively deter and control fraud, while at the same time define reasonable standards and afford due process.

"We wish to offer the assistance and expertise of our Society in the formulation of emergency legislation to empower the Department to suspend and terminate providers guilty of defrauding the program, while safeguarding the rights of honest program participants. Please be assured of our commitment to a Medicaid program which strives for quality care for recipients, fairness to providers and accountability to the public."

Obituaries

***Bedard Robert E.**, Kankakee, died July 27 at the age of 67. Doctor Bedard was a 1933 graduate of the University of Illinois.

***Egan, William B.**, River Forest, died September 27 at the age of 74. Doctor Egan was a 1929 graduate of the Loyola University Stritch School of Medicine.

***Fisherman, Elmer W.**, Highland Park, died July 15 at the age of 58. Doctor Fisherman was a 1948 graduate of the Chicago Medical School.

***Fox, Morris J.**, Wood Dale, died September 20 at the age of 67. Doctor Fox was a 1940 graduate of the Chicago Medical School.

***Cutridge, George H.**, DeQuoin, died July 31 at the age of 80. Doctor Cutridge was a 1928 graduate of the Chicago Medical School.

Nesbit, Robin, Chicago, died October 12 at the age of 26.

****O'Connell, John T.**, Chicago, died September 24 at the age of 83. Doctor O'Connell was a 1917 graduate of the Stritch School of Medicine.

****Pierzynski, Thaddeus Stanley**, Chicago, died February 16 at the age of 86. Doctor Pierzynski was a 1914 graduate of the University of Illinois.

Pert, Louis, Lincolnwood, died August 31 at the age of 64.

***Popper, Hans L.**, Chicago, died September 12 at the age of 79. Doctor Popper was a 1922 graduate from Wren, Austria.

***Singer, Louis G.**, Los Angeles, California, formerly of Chicago died July 21 at the age of 77. Doctor Singer was a 1925 graduate of the Stritch School of Medicine.

***Trummel, Russell Grove**, Macomb, died August 25 at the age of 75. Doctor Trummel was a 1938 graduate of the University of Illinois.

Zelman, Morris, Mt. Vernon, died July 16 at the age of 62. Doctor Zelman was a 1942 graduate of New York Medical College.

**Indicates member of the ISMS Fifty Year Club.*

**Indicates ISMS member.*

Letters to the Editor

A Cross-Cultural Verification

The following is a response to "Teething in Infancy: A Part of Normal Development," by Harvey Kravitz, M.D., Benjamin Emanuel, M.D., Joseph Kasper, Ph.D. and Arthur Neyhus, Ph.D., which appeared in our April, 1977 issue (Volume 151, No. 4, 261-266).

Harvey Kravitz, M.D.
c/o Illinois Medical Journal
Dear Doctor Kravitz:

I am a pediatrician doing general medical work among the Shuar (Jivaro) and Achuar Indians of the upper Amazon valley. In the discussion portion of your study you note that "... drooling, biting objects and hand biting occur most frequently during the third and fifth month of life, when the early teethers, normal age teethers and late teething groups are com-

pared. This suggests that these signs may be developmental in origin rather than related to the eruption of the first deciduous tooth. . . ." Shuar infants also exhibit drooling, biting objects, hand biting at 3 and 4 months of life. The median age (and the normal age) for the eruption of the first deciduous tooth is at ten months of life instead of the 6 month age generally seen in the USA. This would tend to confirm your idea of its being developmental in origin. I certainly think so.

Hope this has been of help.

Greetings from the upper Amazon Valley.

Thomas Brown, M.D.
Medical Director
Centro Medico "San Jose"
Taisha (Morona-Santiago) Ecuador

BY PROCLAIMS WOMAN SUFFRAGE

s Certificate of Ratification
at His Home Without
Women Witnesses.

TANTS VEXED AT PRIVACY.

ated Movies of Ceremony,
But Both Factions Are

SHINGTON, Aug. 26, 1920—
struggle for Women



TRUMAN CLOSES D NATIONS CONFERENCE H PLEA TO TRANSLATE ARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great
Instrument of Peace,'
Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing
Ovation as Executive

"If we fail to use it," he declared
to the solemn final meeting of the
delegates, "we shall betray all of
those who have died in order that
we might meet here in freedom and
safety to create it."

"If we seek to use it selfishly—for
the advantage of any one nation or
any small group of nations—we
shall be equally guilty of that be-
trayal."

Fervent Interpolation

The President, speaking in the
auditorium of the War Memorial
Opera House, built in memory of
sons of the Golden Gate city who
gave their lives in the first World
War, in which he himself served,
seemed to give unconscious expres-
sion to the solemn feeling of the
occasion when, at the outset of his
speech, he interpolated the words,
half a hope, half a prayer:
"O God, grant that the peace agree-

Social Security Bill Is Signed; Gives Pensions to Aged, Jobless

Roosevelt Approves Message Intended to Benefit 30,000,000
Persons When States Adopt Cooperating Laws—He Calls
the Measure 'Cornerstone' of His Economic Program

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution
is Sent to House, Where
Passage is Expected

WASHINGTON, March 10,
1971—The Senate approved
today, 94 to 0, and sent to the
House for passage a measure

WASHINGTON, Aug. 14
The Social Security Bill, providing
a broad program of unemployment
insurance and old age pensions,
and counted upon to benefit
20,000,000 persons, became law
today when it was signed by Presi-
dent Roosevelt in the presence of
those chiefly responsible for its
passing through Congress.

Mr. Roosevelt called the bill
"the cornerstone in a new social
policy which is being built to meet
the needs of a new world."
The bill, which is being built to
meet the needs of a new world,
means complete relief to the
unemployed and the aged.

SIGNING the Draft Ends Now

WASHINGTON, Jan. 27,
1973—"With the signing of
the peace agreement in
Paris today, and after re-





Illinois Medical Journal

DECEMBER, 1977

Vol. 152, No. 6

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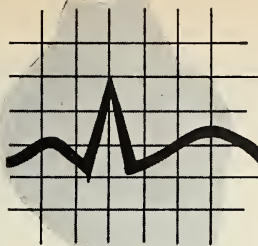
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The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.

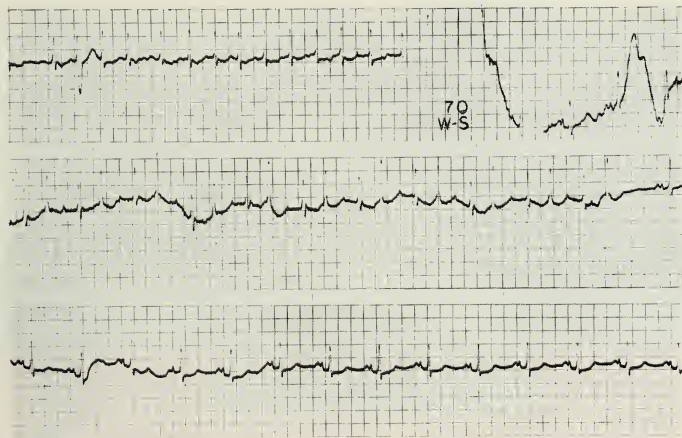




ekg of the month

JOHN F. MORAN, M.S., M.D., DAVID L. FISHMAN, M.D.,
PATRICK J. SCANLON, M.D., SARAH A. JOHNSON, M.D.,
JOHN R. TOBIN, M.S., M.D., AND ROLF M. GUNNAR, M.S., M.D.
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

The patient is a fifty-nine-year-old man with a long history of rheumatic heart disease. He had developed dyspnea on exertion and subsequently near-syncope. These symptoms lead to cardiac catheterization and coronary arteriography. Although the coronary arteries were normal, he had severe mitral stenosis, mild mitral regurgitation, severe aortic stenosis, and mild aortic insufficiency. He later had open heart surgery, aortic, and mitral valve replacement. For five months, he gradually increased his exercise tolerance and took his medications: Digoxin, Furosemid, Warfarin anticoagulation, and KCL. Then he suddenly fell ill and became dyspneic, ashen, diaphoretic, and hypotensive. In the emergency room, it was decided to do an immediate D.C. cardioversion. The ECG rhythm strip is shown.



Questions:

1. The ECG rhythm strip shows:

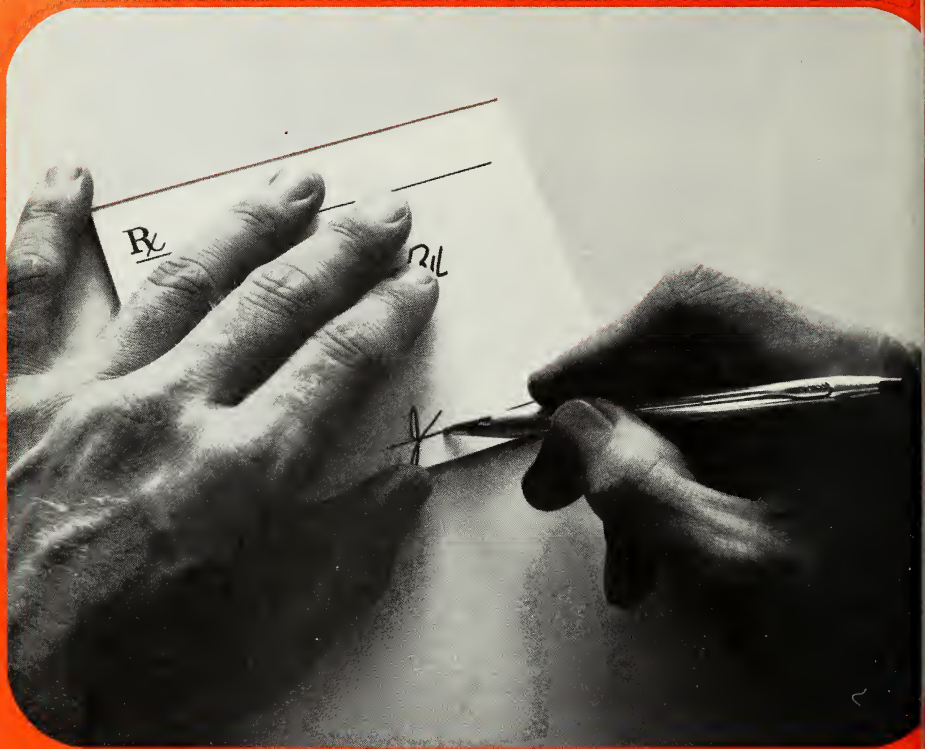
- Atrial fibrillation at a rate of approximately 150/minute.
- A 70-watt-second (W-S) D.C. countershock.
- A post-countershock arrhythmia consisting of atrioventricular dissociation, junctional escape beats, and premature ventricular beats.
- Sinus rhythm with left atrial enlargement.
- All of the above.

2. Which of the following statement(s) are true?

- Digoxin can now be continued.
- Immediate D.C. cardioversion should be used in severe hemodynamic dysfunction caused by the cardiac arrhythmia barring intraindications.
- Systemic emboli are associated with atrial fibrillation.
- Maintenance of sinus rhythm may require Quinidine therapy.
- All of the above.

(Continued on page 498)

There is no substitute



yours...

Contraindications: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.

Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy.

Use in Pregnancy: Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults.

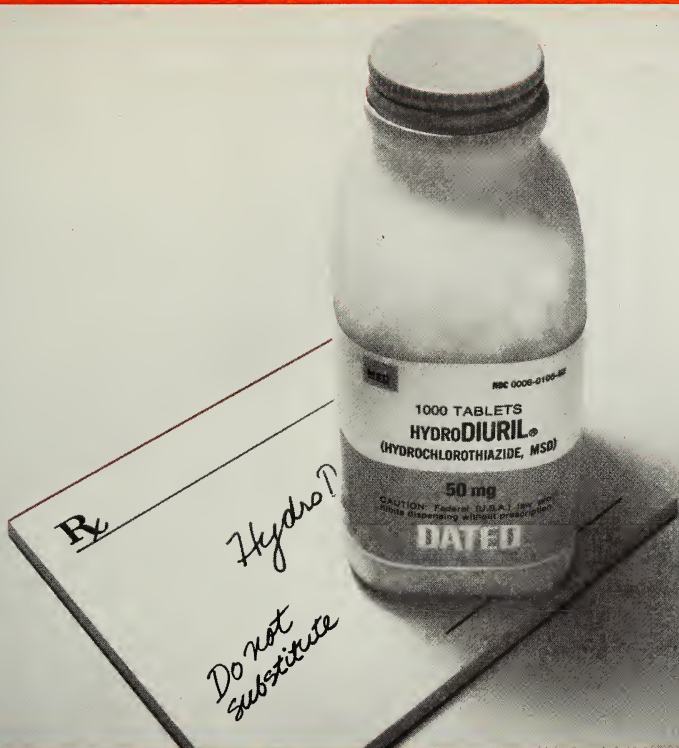
Nursing Mothers: Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.

Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting ex-

cessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

for experience—



or ours.

firmament becomes evident, consider withholding or discontinuing therapy. Thiazides may decrease serum PBI levels without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged therapy; thiazides should be discontinued before testing parathyroid function.

Adverse Reactions: **Gastrointestinal System**—Anorexia, gastric irritation, nausea; vomiting; cramping; diarrhea; constipation; jaundice (intrahepatic cholestatic jaundice); pancreatitis; sialadenitis. **Central Nervous System**—Dizziness; vertigo; paresthesias; headache; anopsia.

Hematologic—Leukopenia; agranulocytosis; thrombocytopenia; aplastic anemia.

Cardiovascular—Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity—Purpura; photosensitivity; rash; urticaria; necrotizing glomerulonephritis (cutaneous vasculitis); fever; respiratory distress including pneumonitis; anaphylactic reactions.

Other—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; weakness; restlessness; transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

Caution: When used with other antihypertensive drugs, careful observation for changes in blood pressure must be made, especially during initial therapy. Dosage of other antihypertensive agents must be

reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.

How Supplied: Tablets containing 25 mg hydrochlorothiazide each in bottles of 100 and 1000 and single-unit packages of 100; Tablets containing 50 mg hydrochlorothiazide each in bottles of 100, 1000, and 5000 and single-unit packages of 100; Tablets containing 100 mg hydrochlorothiazide each in bottles of 100.

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"Ask not what your medical society can do for you . . ."

BY LINDA L. HUGHEY, M.D./WILMETTE

This is a monthly column which welcomes contributions, comments, and questions from interested readers. Address all correspondence to Dr. Linda Hughey, c/o the Illinois Medical Journal, 55 E. Monroe, Chicago, Ill. 60603.

A wave of resident and student interest is growing within the Medical Society. Who are the residents activating the system? Why now? Where will this resurgence of resident interest lead? At one point, the residents and the "establishment" were often at odds with each other about salary, hours, and patient care issues. In fact, they still often disagree. But as more residents join the system via their local medical societies, "they" the Establishment becomes "we" fellow physicians, and our needs become similar.

At some point in training, be it as resident or student, the physician-in-training awakens to two realizations. Medicine increasingly depends on political awareness as well as textbook acumen; individual feelings can do little to change the system. At some point we realize that even though "Blue-Cross-Blue-Shield" and "Medicare" are not mentioned once in Harrison's textbook description of stroke evaluation, they can become critical factors in deciding admissibility and who pays for the EMI scan. Legislative and judicial decisions will have an enormous impact on the way we practice medicine in coming years. The individual physician can do little to change the course of the future.

This realization often does not occur to students early in training because some successful medical school applicants may be loners. Many young physicians only learn the value of group cooperation when they become involved in the teamwork of clinical training. No individual opinion carries as much weight as a consensus of many individual opinions. Many young physicians are turning to their local medical societies for both information about the extra-medical (i.e., political and social) dimensions of the profession and a means of gaining strength through numbers. The local medical society, then, answers the young physician's need to learn to cope with things never taught in medical school and to deal as a group with issues about which individuals can do little.

These aspects are, of course, above and beyond the real but more typically cited reasons for joining the ISMS: the journals, the conferences,

the insurance policies. In a time of moon-lighting housestaff and skyrocketing malpractice insurance costs, the last-mentioned item must account for at least some of the new-found housestaff interest in the ISMS.

Housestaff physicians who wish to become more deeply involved in the activities of the ISMS have several alternatives.

(1) *The Governing Council:* is formulated as one representative from each housestaff association and three members at large. At present there are several openings on this council which meets approximately every six weeks and coordinates other housestaff activities.

(2) *Councils:* ISMS Councils range from "Mental Health and Addiction" to "Governmental Affairs." Many of the councils have a spot open for a resident, and details about council functions and applications will be presented in future columns.

(3) *Conventions and Delegates:* Resident input into ISMS and AMA conventions is almost entirely via the Resident Physicians section of the ISMS.

We would like to build up a file of interested candidates to have on hand as openings arise. Any interested housestaff officer is encouraged to send a letter to Dr. Hughey, c/o ISMS at 55 E. Monroe, Chicago 60603 explaining individual interests. A resume would also be useful.

For those of you who are new members, welcome to the Illinois State Medical Society. We welcome your input into the Residents' section, as we hope to have a broadly based, active group of residents participating constructively in the ISMS activities. Welcome!

Input Request

Every month we shall present a profile of Housestaff officers who are involved in ISMS councilwork or in other Housestaff projects of general interest. If you know of projects, activities, or individuals of note to our readers, please let us know and we shall consider a profile of them in future issues.

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REPORT

FOR *Illinois Physicians*

Physicians Featured Speakers At Blue Cross/Blue Shield Symposium

Four nationally known physicians were featured speakers at the recent symposium on "The Future of Health Care in America," sponsored by the Chicago-based Blue Cross and Blue Shield Plan.

They are James H. Sammons, M.D., executive vice president of the American Medical Association; Jonas Salk, M.D., discoverer of the Salk Polio Vaccine; Kenneth Cooper, M.D., known as the "guru" of American joggers; and John H. Knowles, M.D., president of the Rockefeller Foundation.

Dr. Sammons sharply criticized proposals for national health insurance, one of the topics discussed during the day-long meeting in the Conrad Hilton Hotel in Chicago. Saying every nation that has adopted NHI has "frozen" medically, he stated "Rationing of health care seems to be at the bottom of what the federal government is really after—regardless of the high-minded motives displayed on the surface."

He noted that under Britain's National Health Service there are 600,000 people who have been waiting for elective surgery for six months to four years. Dr. Sammons said, "It is sadly ironic that in the name of freer competition in our industry, the government is rolling toward its own monopoly over us."

Dr. Salk, who was the featured speaker during a luncheon in the hotel's Grand Ballroom, called for establishment of an H.D. (Health Doctor) degree, designed to promote health instead of fighting disease. The H.D. would be concerned with lifestyle and factors in the environment that promote health. The science and art of health would join with the science and art of medicine, he explained.

Dr. Salk, who is doing research on cancer and multiple sclerosis at his Salk Institute of Biological Studies, said the nation is entering a new epoch.

"The change is from anti-disease to pro-health with an emphasis on preventive measures," he said.

The noted physician said, "We should pay attention to the wholistic theory of looking at health in terms of bringing the parts together into the whole. I am optimistic that health will be better if we become more aware that we are into a new epoch and if we make the right choices from the options we have."

Dr. Cooper, originator of the Aerobics exercise program, cited evidence that people who stay fit

live longer. He said, "Exercise is the best preventive medicine of all." Dr. Cooper said people have come from all over the world to jog at his Aerobics Center in Dallas, logging a total of 1.4 million miles.

He said most of the leading causes of death can be reduced dramatically if people would change their lifestyle by following a regular exercise program and giving up bad habits.

Dr. Knowles also talked about lifestyle, pointing out that prevention of disease means "forsaking the bad habits which many people enjoy—overeating, too much drinking, taking pills, driving too fast, smoking cigarettes."

He said, "The cost of sloth, gluttony, alcoholic intemperance, reckless driving and smoking is now a national and not an individual responsibility. This is justified as individual freedom, but one man's freedom in health is another man's shackles in taxes and insurance premiums."

Joining the physicians on the program were Plan President S. Martin Hickman; Illinois Gov. James Thompson; U.S. Sens. Abraham Ribicoff and Charles Mc. Mathias; former Sen. Robert Taft; U.S. Rep. James Corman; pollster Patrick Caddell; Vernon Loucks Jr., president of Baxter Travenol Laboratories; columnist Carl T. Rowan; Stanford University Prof. Victor Fuchs; consumerist Bess Myerson, and Olympic decathlon champion Bruce Jenner.

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Medicare to Pay for Second Opinion On Potential Surgery Patients

The Department of Health, Education and Welfare has notified Medicare carriers that reimbursement can be made on a second physician opinion when surgery is being considered; especially such procedures as hysterectomies, radical mastectomies, prostatectomies, bunionectomies and such.

Medicare is recommending and encouraging that potential surgery patients seek a second physician opinion. The carriers are instructed to make payment on claims for patient-initiated second physician opinions pertaining to the need for surgery. Medicare reimbursement can be made for the history and examination of the patient, as well as any other covered diagnostic services required for the physician to properly evaluate the patient's condition and render a professional opinion on the medical need for surgery. If the recommendations of the first and second physician differ regarding the

medical need for such surgery, reimbursement can be made for an opinion by a third physician. Reimbursement will be made, even though the patient has the surgery performed against the recommendation of the second (or third) physician.

Until charge data for patient-initiated second (or third) opinions can be accumulated, reimbursement will be based on the reasonable charges allowed for consultations. In order to accumulate the needed charge data, Medicare is asking for the physicians cooperation in specifying on their claim forms or bills, whether the service is a second or third opinion.

Consultations, limited or comprehensive, should be identified as before; including the name of the referring physician. If claims are received by Medicare without the name of the referring physician, Medicare will be contacting the physician's office to determine whether the service is a physician-initiated consultation or a patient-initiated second opinion.

Changes in Participation and Location of Labs

The Bureau of Health Insurance, Social Security Administration, has issued notices that the following laboratories are closed, and that no payment can be made under the health insurance program for services rendered on or after the effective closing dates. The laboratories are:

Sarian Medical Laboratory
7101 South Archer Avenue
Chicago, Illinois 60638
Provider Number: 14-8011
Effective Date: September 1, 1977

Chatham Avalon Clinical Laboratory
2165 North Milwaukee Avenue
Chicago, Illinois 60670
Provider Number: 14-8060
Effective Date: August 27, 1977
P.M. Clinical Laboratory

6160 Joliet Road
Countryside, Illinois 60525
Provider Number: 14-8205
Effective Date: September 1, 1977

Laboratory Openings

Rodes Medical Laboratory
1816 West Irving Park Road
Chicago, Illinois 60613
Provider Number: 14-8339
Effective Date: June 6, 1977

Relocation

Medic Clinical Laboratory has relocated to:
6144 West Roosevelt Road
Oak Park, Illinois 60304
Provider Number: 14-8172
Effective Date: July 22, 1977

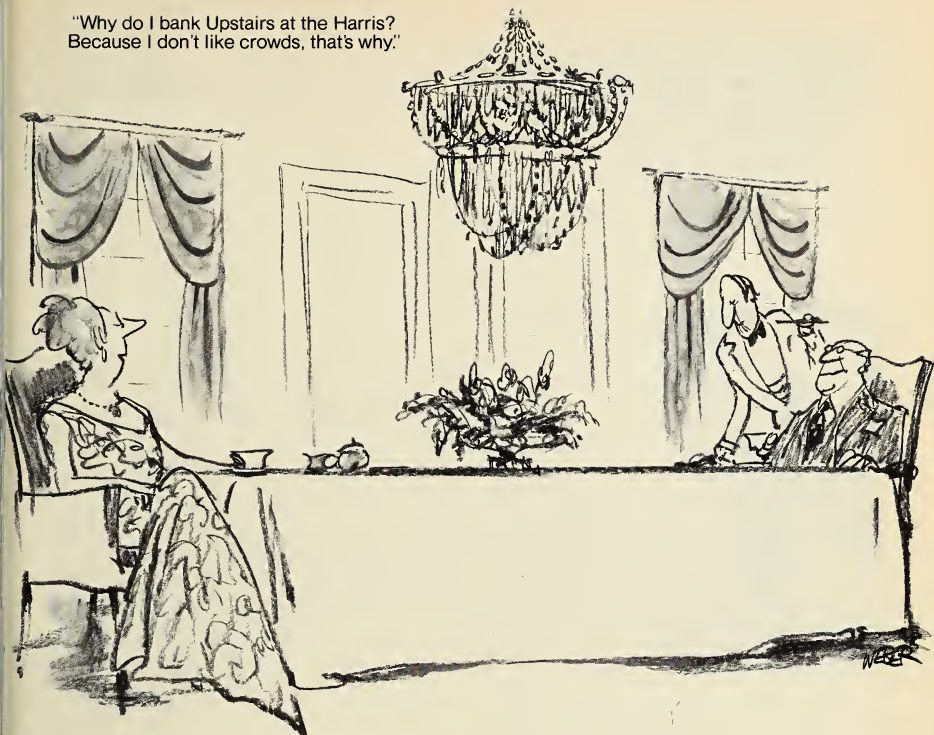
Anchor Organization Laboratory has relocated to:
6033 North Sheridan Road
Chicago, Illinois 60660
Provider Number: 14-8286
Effective Date: June 1, 1977

Community Medical Laboratory has relocated to:
9300 South Ashland Avenue
Chicago, Illinois 60620
Provider Number: 14-8175
Effective Date: August 19, 1977

New Portable X-Ray Certification

Avenue Medical Laboratory, located at:
16234 South Louis Avenue
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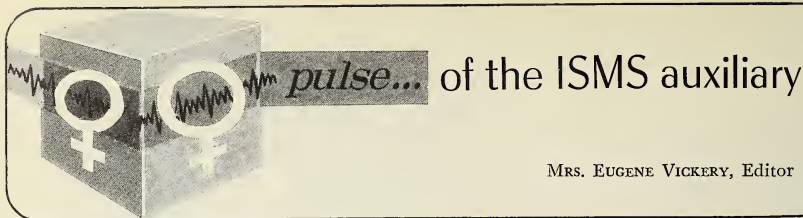


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KEY LINES:

By BETTY SZEWCZYK, PRESIDENT, ISMSA

Leadership Logistics

Many educators have preached, and even some students have believed, that learning can be fun. As participants of the AMAA Leadership Confluence that took place in Chicago, October 9 through 12, thirteen fortunate Illinois auxiliary members absorbed and enjoyed three days of leadership training. Perhaps one of the weaknesses in auxiliary organization has been a lack of training for future leaders. The third annual AMAA Leadership Confluence whittled away at this weakness and sent home presidents-elect who are not only enlightened regarding auxiliary aims, programs and community projects, but also enthused and motivated to do a dynamic job for the coming year.



It began Sunday night with a dinner presided by Mrs. Chester Young, AMAA president, followed by the keynote address by Dr. John Budd, American Medical Association president. His encouraging and inspirational talk was followed by a tri-screen slide presentation prepared for the 55th Anniversary of the AMAA. The evening ended with the "State Exhibit Walk" which gave all participants an opportunity to see the highlights of the year from each state. One particularly interesting exhibit was a skateboard safety program. Slides on the subject are now available for use; for further information, contact your president.

Monday was "Priority Seminars" day—designed to provide auxiliary leaders with the opportunity to obtain information on key programs. The American Medical Association Education Research Foundation (AMAERF) was the first topic. Participants learned that: AMAERF is

the only national philanthropic fund-raising auxiliary project; to date the Foundation has distributed voluntary gifts of more than 28 million dollars directly to the nation's medical schools and that the schools are notified of individual donor's name, and amounts of individual gifts; contributions designated for the Loan Guarantee Fund may not be designated to a specific medical school; during the year ending December, 1976, 5,547 loans, totalling \$7,814,000 were made through the AMAERF Loan Guarantee program—a 49% increase over the previous fiscal year; the check presented by the AMAA president to the House of Delegates during the San Francisco convention last June totalled \$1,512,566.18.

Communications opened with a description of the Immunization Awareness project that included spot announcements featuring the "Hopscotch" which have been provided to every com-

mercial television station in the country. Also shown was a five minute film of appeal to younger children, which featured puppets named for controllable diseases. Groups of participants were given "problems" involving communications within the auxiliary, the medical society, the community and media. Many of the answers were innovative and hopefully will prove useful.

At the *Legislative* seminar, the emphasis was on understanding and working together. Awareness of legislative activity, at least in a general way, and initiating activity at the state level was stressed. It was suggested that auxiliary legislative chairmen might attend Society meetings as a positive approach to auxiliary participation and citizen involvement.

Membership provided an opportunity to see our own reflections in the membership "mirror." Some interesting points were stressed: dues dollars are not a reason for joining or quitting but merely an excuse; individual communication with new and prospective spouses; general public relations; "reach out" programs with interns and residents to identify young spouses; membership appeal to male spouses.

Eight "Topic Seminars" were presented on Tuesday, from which participants could choose four. Each seminar was conducted by experts on the subject.

The *Impaired Physician* seminar focused on the impaired physician and his family, concentrating particularly on the spouse's role in case-finding and referral, including the family's role in the treatment process. The seminar also offered practical information on activities that auxiliaries can initiate in their states and communities to help impaired physicians and their families.

On Being a Woman—Today's woman lives in rapidly changing times. Old wives' tales and medical fiction should be a thing of the past in this enlightened age.

Parliamentary Procedure seminar was specifically designed to help state and county leaders on problems of presiding and preparation of agenda items at meetings. The seminar was directed by an expert in the field, Mrs. Roscoe Mosiman, parliamentarian.

The ideal school health education curriculum extends from kindergarten through 12th grade. It provides the child with a sequence of health learning experiences that build on one another up through the grades, the primary focus on which is health promotion, not disease prevention. The *School Health Education* seminar dis-

cussed relative merits of the comprehensive approach and the more limited problem-centered curriculum module. Examples were presented along with suggestions for auxiliary involvement.

Techniques for Speakers was skillfully designed to provide methods for achieving the basic communication skills most frequently needed by auxiliary leaders—including speaking to inform and persuade. Teaching and showing perfect example were Mortimer T. Enright, director, AMA Speakers and Leadership Program, and T. Stephen May, Ph.D., chairman, Radio-Television Division, Northwestern University.

There is no single way to study or write about television because it means so many different things to so many different people. As a society, we have something of a love/hate relationship with television. Parents can share the television viewing experiences to help their children discover themselves, or their values. The *Television* seminar provided an opportunity to develop further knowledge and insight.

Value changes can be said to arise from many different sources. The *Family Unit-Shifting Values* seminar dealt with the sources of value changes. Parents have the capacity to create loving human beings who are productive in society.

Volunteer Services for the Aging offered assistance to local auxiliaries in establishing community projects to help insure self sufficiency by home-bound care instead of institutionalization. Supportive services and projects included home-maker home-health aide service, friendly visiting and telephone reassurance programs.

Wednesday morning's Open Forum Session was by invitation only to State Presidents, State Presidents-Elect, State Auxiliary Staff Executives and National Board of Directors. While these leaders were finding answers to their many questions, and listening to Dr. James Sammons, Executive Vice President, AMA, the county presidents-elect were hurrying home with their enthusiasm and ideas for medical auxiliary.

Illinois attendees included: Adams County, Mrs. Walter Stevenson, Quincy; Cook County, Mrs. Walter Olszewski, Evergreen Park; Ogle County, Mrs. Thomas Koritz, Rochelle; Lake County, Mrs. David Heinrich, Lake Forest; Macon County, Mrs. Otto Brosius, Decatur; McLean County, Mrs. Wil Thielemann, Carlock; Kankakee County, Mrs. Randall Mann, Kankakee; St. Clair County, Mrs. Thomas Meirink, Belleville; Will-Grundy, Mrs. Robert Kleinhoffer, Joliet; and Winnebago, Mrs. Louis Tisovec, Rockford.

Obituaries

*Ball, Fred E., Florida, formerly of Chicago, died August 27 at the age of 78. Doctor Ball was a 1923 medical school graduate.

Firoozi, Ferydoon, Chicago, died in October at the age of 44.

Garren, Donald R., Greenview, died October 6 at the age of 45.

**Knapp J. L., Chicago, died October 7 at the age of 94. Doctor Knapp was a 1908 graduate of the University of Illinois.

*McMillan, Robert G., Chicago, died July 17 at the age of 71. Doctor McMillan was a 1931 graduate of the University of Illinois College of Medicine.

Siler, Marion, Oak Park, died in October at the age of 89.

Stein, Alfred B., California, formerly of Illinois, died early in November.

**White, Cleveland J., Oak Park, died October 8 at the age of 84. Doctor White was a 1922 graduate of Rush Medical College.

Wilson, James R., Colorado, formerly of Illinois, died in late October at the age of 80. Doctor Wilson had at one time been chairman of the ISMS Committee on Nutrition.

*Indicates ISMS member.

**Indicates member of the ISMS Fifty Year Club.

ISMS Travel Program

Four of the ISMS travel programs scheduled for 1978 remain open for reservations. These include trips to Egypt-Greek Isles (May 5-19); Scandinavia (July 6-20); Imperial Europe (Sept. 5-19) and the Eastern Mediterranean Air/Sea Cruise (Nov. 1-14).

Descriptive brochures will be mailed five months in advance. Reservations cannot be accepted without the official form printed in these brochures. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. *Promotional expenses connected with these programs are paid for by the tour operator.* For further information, contact ISMS headquarters.



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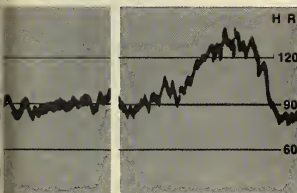
Sex and the heart patient:

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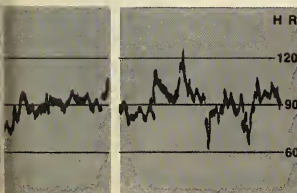
Over 80% of post-coronary patients ultimately resume sexual activity without serious risk. Hellerstein and Freedman demonstrate that mean maximal heart rate during orgasm with spouse (as opposed to extramarital sex) in 14 post-infarct patients is lower than that during usual occupational activity.

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A. Working in office about 90 beats/min

B. Confrontation in judge's chamber (about 125 beats/min)



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D. Peaks at orgasm (120 beats/min)



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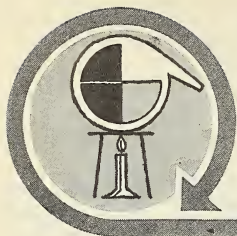
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BY PAUL DEHAEN

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TOPICORT Local Corticoid Rx
Manufacturer: Hoechst-Roussel Pharmaceuticals, Inc.

Nonproprietary Name: Desoximetasone
Indications: Inflammatory manifestations of corticosteroid dermatoses

Contraindications: Vaccinia, varicella and hypersensitivity of patients

Dosage: Apply thin layer to affected areas twice daily

Supplied: Tubes, 15 g; cream 0.2%

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Manufacturer: Warner-Chilcott
Nonproprietary Name: Prazepam
Indications: Symptomatic relief of anxiety states

Contraindications: Narrow angle glaucoma
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NEW SINGLE BIOLOGICALS

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Manufacturer: Abbott Laboratories
Nonproprietary Name: Hepatitis B Immune Globulin (Human) (HBIG)
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Antazoline phosphate 0.5 % with solvents

Indications: Ocular irritation and inflammatory or infectious ocular conditions

Warning: Do not use in presence of narrow angle glaucoma

Dosage: One or two drops instilled in each eye 3 or 4 hours apart
Supplied: Dropper bottle, 15 ml

XERAC BP Dermatologic Preparation Rx
Manufacturer: Person & Covey, Inc.
Composition: Benzoyl peroxide 5% and 10%
Lauret-4
Carbomer-934
Triethalonamine
Disodium EDTA

Indications: Management of acne
Administration: Wash affected area and apply once or twice daily, adjust to response

Supplied: Plastic tube, 45 g

1977 ISMS State Fair Booth

By JACOB E. REISCH, M.D., SPRINGFIELD

The Illinois State Medical Society's Hypertension Detection Center at the 1977 Illinois State Fair again achieved its intended objectives: to provide a health-care service for State Fair attendees by evaluating their blood pressure as well as alerting them to the potential dangers of hypertension and to publicize the Society's interest in the provision of quality medical care for Illinois citizens.

The 1977 project exceeded past years in effectiveness and numbers. A blood pressure check at the Fair in the ISMS "Office" has become a habit and tradition for many persons. The "annual follow-up visit" load has increased each year and often a friend is brought along, each a sure sign of approval and appreciation.

The 1977 operation was staffed by representatives of the Division of Pulmonary Medicine of the Memorial Medical Center in Springfield. Thirty-six technicians and receptionists kept the long lines moving at a reasonable pace. They rotated on four-hour shifts, with a minimum of six persons on each. The "patients" were truly cosmopolitan and typical of the Average American—young and old; black, white and others, male and female. They collectively provided the opportunity for a true profile of average blood pressure "on the go". Over 1000 individuals were checked each day in air-conditioned comfort and informed about their blood pressure health. All examinations were done in privacy in the Society's four-treatment-room mini-office adjacent to the reception and registration areas. The office is equipped with comfortable chairs, a desk and other essentials, thereby assuring each visitor comfort in addition to a brief respite from the soaring August heat.

Preliminary study of the findings indicate that 1,963 persons (20.13% of those checked) had blood pressures above that considered as "average" normal. In other words, one-fifth of those checked were potentially ill, although many were not aware of it. This figure is slightly lower than that of last year.

Each visitor was also provided a brief education in the potential dangers of high blood pressure—"The Silent Killer"—by means of a brochure especially developed for the Fair, called "How to Avoid a Stroke." This same information was presented visually in the "reception room"

by means of a constantly repeating slide series. A six-foot-high sphygmomanometer also attracted considerable attention. Illuminated from the rear by a bright flashing strobe light, it clearly defined systolic and diastolic areas as well as that area where pressures are considered "normal."

For a permanent record, each participant was given a bi-fold wallet-sized ISMS Blood Pressure Record Card. When the pressure was taken, it was recorded on the card by the technician and the individual urged to record future readings on it for an extended record of their pressure. Space on the card is also provided for personal information and medical history of importance. These cards have been in high demand ever since their introduction four years ago, and many calls are received for them throughout the year.

For 29 consecutive years the State Medical Society has provided the public with medical or other general health information in one form or another at the Illinois State Fair. It is the only public "showing" the Society has and this format could profitably be employed for additional "exposure" in other areas. From a meager start in a small tent (to achieve darkness) under a hot grandstand where "health movies" were shown, the exhibit's stature has progressed to a neatly paneled area housing a four-room mini-office.

It is often difficult to immediately evaluate the benefits achieved from a PR project since the only tangible evidence is the number of individuals it reaches. Publicity attempts of many organizations are looked upon with cautious skepticism, primarily because large organizations are considered cold, impersonal and unconcerned with anyone other than their members. And this is all too often true. There is no question that ISMS' public image has been enhanced through its demonstrated concern for the public's well-being. It is also undoubtedly true that one or more lives have been saved by the early and initial detection of hypertension in some individuals. And on a different level, the image of the physician has been polished a bit, for the "patients" are reminded that it is the physicians who made this detection program possible. This is one certain way of making friends for the profession and with the heavy step of federal medical care approaching ever closer, medicine needs as many friends as it can muster.

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Illinois Medical Journal

Vol. 152, No. 6, December, 1977

Large Migrating Hepatic Adenoma Associated With Use of Oral Contraceptives

BY IRVING WEISSMAN, M.D., MICHAEL J. RUSSO, M.D. AND
ROBERT W. BRUNNER, M.D./CHAMPAIGN

Until the past decade, benign hepatic adenomas were considered extremely rare.¹ Recently, more and more of these unusual liver tumors are being reported in the literature.¹⁻⁷ In addition, there is evidence to suggest a causal relationship between these tumors and use of oral contraceptives. This case is presented because of a large upper abdominal mass so mobile as to make it

difficult to detect clinically and diagnose correctly. It is emphasized that differential diagnosis of an abdominal mass in a young female using oral contraceptives should include a benign liver tumor.

Case Report

A 26-year-old gravida I, para I, divorced female was first seen by her local medical doctor complaining of a vague mass in her upper abdomen. The mass seemed to produce an intermittent bulge above the umbilicus. She gave a history of taking birth control pills (Ortho-Novum®-2mg.) for approximately six years, except during one pregnancy. Physical examination revealed a well nourished white female who, when first examined, had no detectable abdominal mass. She had no gastrointestinal complaints, no weight loss or abdominal pain. Radiological examination of the upper gastrointestinal tract revealed a large mobile mass arising primarily in the right upper quadrant, extrinsically displacing the stomach and duodenum to the left and anteriorly (Fig. 1, 2 and 3). Fluoroscopically, as the patient rotated from supine to left lateral position, the mass easily moved across the upper abdomen to the left. Film examination clearly showed a normal right lobe of liver. An intravenous pyelogram (Fig. 4) showed the mass lying anterior to and effacing the right kidney. There was no urinary obstructive disease and the pyelogram was otherwise normal.

Following the X-ray studies, re-examination



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MICHAEL J. RUSSO, M.D., is a general surgeon in private practice and clinical associate of the School of Basic Medical Sciences in Champaign-Urbana. Doctor Russo is a past president of both the Champaign County Medical Society and the Illinois Chapter of the American College of Surgeons.

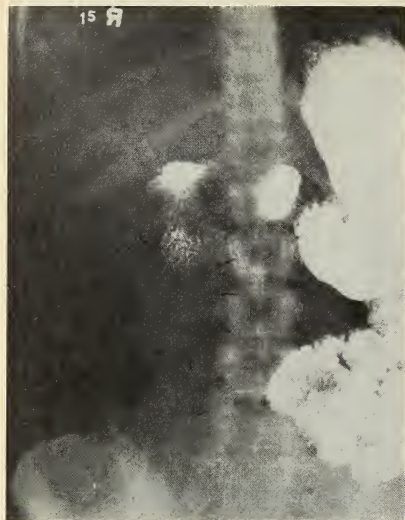


Figure 1

Upper gastrointestinal examination showing displacement of stomach and duodenum to the left by mass in right upper quadrant. Note normal outline of right lobe of liver.



Figure 2

Small bowel study shows right upper quadrant mass displacing loops of small bowel and hepatic flexure of colon to the left.

confirmed a ballotable mass in the upper abdomen best seen when the patient was upright or leaning slightly forward. The mass moved with respiration but appeared to be separate from the liver. The liver margin was normal on physical examination. Blood values and liver function studies were normal. A liver scan showed a normal-appearing right lobe and evidence of extrinsic pressure on the left lobe, but no uptake to outline an adenomatous tumor of the liver (Fig. 5). Because the mass was mobile, displacing loops of bowel, an omental or mesenteric cyst were considered and laparotomy recommended. It should be noted that sonography would have certainly revealed a solid rather than cystic mass and may have led to a more realistic diagnosis.

Laparotomy performed on January 14, 1977 revealed a solid mass, twelve centimeters in diameter, attached to the left lobe of the liver adjacent to the round ligament. The right and left lobes were not enlarged or involved. The mass was attached to the edge of the left lobe of liver by a thin pedicle and was easily resected.

Pathologically, the specimen was reported as an adenoma of the left lobe of the liver and weighed 510 grams (Fig. 6). Sections were also submitted to the Armed Forces Institute of Pathology where a hepatocellular adenoma was confirmed. The patient made a rapid recovery from surgery and has since remained healthy.

Discussion

Benign hepatic tumors occurring in young women receiving oral contraceptive steroids present themselves either as focal nodular hyperplasia of the liver or as hepatic cell adenomas.^{1,2,5} Although pathologically benign, the disease is not without hazard.⁹ Twelve of 35 reported cases had massive intraperitoneal bleeding and 5 deaths have been reported.⁵ According to Nissen *et al.*,^{1,8} liver scans, celiac arteriography and standard liver function tests are ineffective in identification of these tumors. Apparently, cases of focal nodular hyperplasia may show localized radioactive concentration on a liver scan but hepatic cell adenomas rarely, if ever, pick up radioactivity. This is apparently because sulfur



Figure 3

Small bowel study—lateral view—showing mass displacing intestinal tract anteriorly. In this position, mass moved to left across upper abdomen.

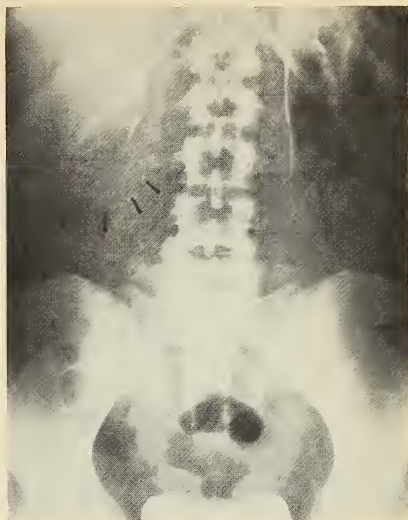


Figure 4

Intravenous pyelogram showing effacement of right kidney by mass. Note clear normal outline of liver.



Figure 5

Liver scan showing normal right lobe of liver but rounded encroachment on left lobe. No uptake in mass which would later prove to be hepatic adenoma.

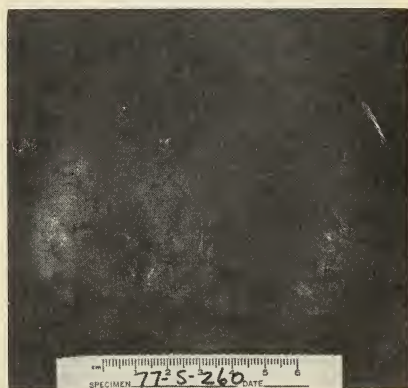


Figure 6

Gross pathological specimen—resected hepatic adenoma.

colloid pickup depends on reticuloendothelial cells. Since most of the adenomas have few Kupfer cells, it cannot concentrate the radioactive particle.

Increasing numbers of the reported cases show a history of oral contraceptive use. Progestin-dominant steroids were more frequently implicated.^{1,8} In the cast reported here, the use of "Ortho-Novum" fits this pattern. This steroid contains 2mg. of Norethindrone and .1mg. mestranol and is the same drug used in several of the reported cases. In a review of all liver tumors at Mayo Clinic from 1907 to 1954 only four hepatic cell adenomas were found.⁴ In a study by McAvoy and his group, in July of 1976, 33 cases were reported in the literature and two additional cases presented.⁵ All were in young women taking oral contraceptives.

Summary

A case of a highly mobile, large liver adenoma on a pedicle, found in a young female with a good history of oral contraceptive use is presented. The diagnostic problems are discussed and it would again appear that history, physical

examination and proper roentgenological studies should lead to a correct diagnosis. In most cases, liver scanning or arteriograms may be deceptively negative. ◀

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A Word of Caution

XEROMAMMOGRAPHY

BY LARRY C. GUNN, M.D./HINSDALE

The experience in treating 151 patients with breast disease who had xeromammography performed before treatment is presented and the indications for mammography are reviewed. The capabilities and shortcomings of mammography in this group of patients are considered. A small subgroup of patients with occult, mammographically discovered carcinomas are included, none of whom proved to harbor axillary metastases.

Mammography is not a substitute for aspiration or biopsy of dominant breast masses, except in occasional individual cases. The gravity of placing too much reliance on mammographic interpretation of clinically suspicious masses is demonstrated by the occurrence of delayed treatment of breast cancer in several patients, following a false negative mammogram.

The incidence of breast cancer per 1,000 patient examinations is 2.7-4.1.¹⁻⁷ It has been clearly demonstrated that the technique of mammography will allow for discovery of the very early occult breast lesion. This diagnostic tool should become a part of our screening programs regardless of its cost.² For example, it has been shown that in patients with very small primary lesions, only 22% have axillary metastases in contrast to 51% who have axillary metastases when the

lesions are clinically demonstrable.⁹ Our experience with xeromammography will be presented.

Clinical Experience

In the period from January, 1972, to December, 1974, 151 patients were referred for further study of breast problems following positive findings by clinical examination or xeromammography. Twenty-three patients were excluded from further study because of obvious benign fibrocystic disease (benignity confirmed by xeromammography).

The remaining 128 patients underwent definitive study, either aspiration or biopsy of the breast masses. As expected, the largest group, numbering 83, consisted of patients whose masses seemed benign on palpation and were then confirmed to be benign with both mammography and biopsy. In this group, one-third of the masses diagnosed as cystic were treated by aspiration



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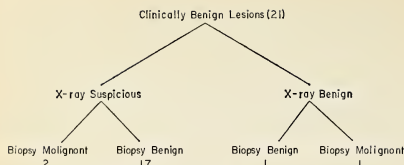


Figure 1

Results of xeromammography and biopsy in 21 patients with clinically benign lesions.

alone, while the other two-thirds were biopsied. Non-cystic masses, such as fibroadenomata, were all confirmed by open biopsy, though some had been aspirated without success. Figures 1-3, which diagram the three remaining subgroups, compare effectiveness of xeromammography with biopsy in evaluating clinically benign, clinically malignant, and occult lesions.

Comment

Current uses of xeromammography include the following:

1. Routine screening of patients older than 35-40.
2. Routine screening of all high-risk patients.
3. An aid in diagnosis of breast masses.
4. Evaluation of the normal breast in a patient undergoing contralateral breast biopsies.
5. Post-mastectomy evaluation of the remaining breast.
6. Evaluation of a patient with diffuse cystic disease.
7. Evaluation of a patient with unexplained nipple discharge.
8. Screening for the primary site of metastatic malignancy.
9. Cancerophobia.

In general, mammography is not helpful in patients younger than 30-35 due to the density of breast tissue in this group.

We cannot fully evaluate the effectiveness of mammography as a screening procedure because our patients were from a selected, referred population. We were able to justify our personal concepts of breast lesion management. We feel that mammography is a useful adjunct in managing the multinodular breast, in treating patients with nipple discharge and in high-risk and post-mastectomy patients. In those patients about to undergo biopsy, mammography aids in preoperative preparation, and additionally, provides a

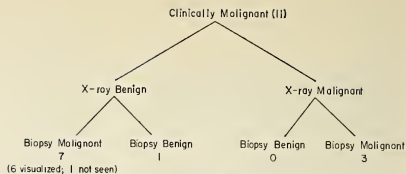


Figure 2

Results of xeromammography and biopsy in 11 patients with clinically malignant lesions.

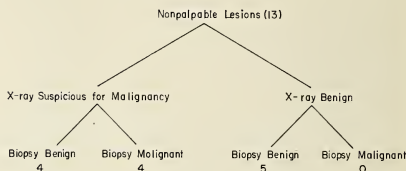


Figure 3

Results of xeromammography and biopsy in 13 patients with non-palpable lesions.

baseline for subsequent examination.

As a substitute for biopsy or aspiration of definite masses, mammography is to be condemned, except for the patient who has multiple nodules in the breast or previously confirmed cysts. As a screening procedure, it cannot be criticized. As could be expected, mammography alerted us to the possibility of malignancy in a clinically benign lesion. On the other hand, a false negative was present in this small series which led to significant delay in beginning appropriate treatment.

Of far greater significance, we found that *clinically* malignant lesions were overwhelmingly shown to be malignant, even when the mammogram failed to demonstrate the lesion or indicated that it was benign (Fig. 2). Failure to biopsy a clinically suspicious mass poses the serious hazard of delaying definitive cancer therapy. Because too much importance had been placed on radiographic interpretation, some patients in this group experienced treatment delays of 2-7 months.

In the management of occult lesions, clinical and specimen mammography is of great value. In non-palpable lesions discovered on mammography (Fig. 3), biopsy always confirmed the lesions to be benign when the X-ray indicated benignity. When the mammograms indicated

suspicious lesions, pathologic examination confirmed 50% of them to be malignant. Since, in this group, none of the five X-ray benign lesions proved to be malignant, perhaps short term radiographic follow-up could be initially employed instead of biopsy. However, we are reluctant not to advise biopsy, given the expected results of early detection of breast cancer.

In most patients with occult lesions, specimen xerography was utilized first to find the mass and then to confirm its removal. These non-calcified benign lesions can now be excised much more easily with the sacrifice of far less breast tissue utilizing the technique of injection mammography.¹⁰ Of the occult carcinomas discovered, three were infiltrating ductal carcinomas treated by radical mastectomy. None of the four patients had axillary nodal metastases. It is to be hoped that these four patients will enjoy the same favorable prognosis which has prevailed for patients with early stage lesions in the past. Patients with lesions found early in the course of the disease may be, in the future, safely treated with lesser operative procedures than are now standard, although this matter remains conjectural. ◀

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COOK COUNTY Graduate School of Medicine

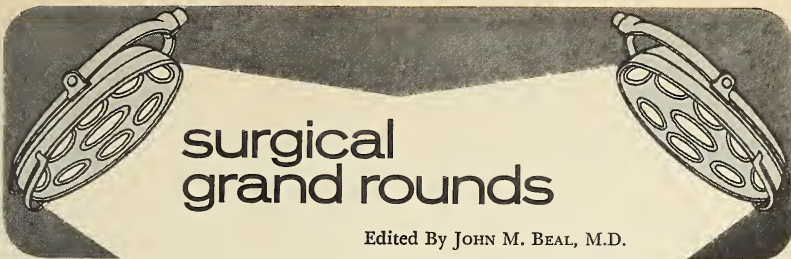
CONTINUING EDUCATION COURSES

STARTING DATES—1978

PLANNING FOR A DIAGNOSTIC RADIOLOGY DEPT., January 5
RECENT ADVANCES IN NEUROLOGY, 5 days, January 23
SPECIALTY REVIEW NEUROLOGICAL SURGERY, February 3
SPECIALTY REVIEW THORACIC SURGERY, February 13
NEUROPATHOLOGY, Six Days, February 27
NEUROLOGY, PART I, BASIC, 5½ days, March 6
BASIC INTERNAL MEDICINE, 5 days, March 6
SPECIALTY REVIEW SURGERY, PART II, March 6
DIAGNOSIS AND MANAGEMENT OF PROBLEMS IN GYNECOLOGY, March 6
BASIC ELECTROCARDIOGRAPHY, 5 days, March 27
EKG FOR ANESTHESIOLOGISTS, 5 days, March 27
ADVANCED EKG, 2½ days, April 3
BASIC REVIEW IN PSYCHIATRY, 5 days, April 3
DIAGNOSTIC RADIOLOGY, 5 days, April 3
SPECIALTY REVIEW PEDIATRICS, 5½ days, April 3
SPECIALTY REVIEW UROLOGY, 5 days, April 10
BASIC SEMINAR & WORKSHOP IN ECHOCARDIOGRAPHY, April 19

Information concerning numerous other continuation courses available upon request.

Address:
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surgical grand rounds

Edited By JOHN M. BEAL, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of August 2, 1977.

Case Report:

Tracheo-Esophageal Fistula

Dr. John Raffensperger: Tracheo-esophageal fistula is one of the more interesting lesions in pediatric surgery. In my opinion, proper treatment requires a pediatric surgeon.

The diagnosis may be made from the nurses' notes. They may notice excessive mucus, or if they feed the baby, he will cough, choke and frequently turn cyanotic.

The first procedure in a child with suspected esophageal atresia is to pass a catheter into the esophagus. It may be inserted either through the nose or mouth, and a 125 catheter should pass readily into the stomach. If esophageal atresia is present, the tube will not pass. If obstruction is encountered, the child should be taken to the X-ray department for a plain film. In the classic anomaly, the catheter will rest in the blind proximal pouch and communication between trachea

and distal esophagus will produce air in the stomach.

There is great temptation to inject contrast material into the catheter for blind proximal pouch visualization. This is not only unnecessary but may be harmful. The contrast agent, water-soluble or not, will spill over into the lungs and increase pulmonary problems.

So, rule No. 1 is to forget the business about putting down contrast material—just use a radio-opaque catheter. The classic type is proximal esophageal atresia. Distal tracheo-esophageal fistula occurs in about 85% of all esophageal anomalies. Atresia may occur with or without fistula and fistula may exist without atresia, but proximal atresia with fistula between trachea and distal esophagus is the classic type.

The first step in treatment is the passage of a double lumen sump tube which is attached to

suction. This will remove saliva and prevent the baby from aspirating. The second step in treatment, in my opinion, is a gastrostomy, because these babies are at risk from aspirating their saliva. If the stomach fills up with air, they will vomit and regurgitate gastric juice into the tracheal-bronchial tree, which also contributes to their pneumonia.

A Second Warning

Rule No. 2: If immediate surgery is not planned, the treatment should be staged with a suction tube in the proximal pouch and a gastrostomy on gravity to drain the stomach.

The baby who is full term and without pneumonia can be resuscitated rather rapidly with intravenous fluids, antibiotics, humidity and suctioning. If there is right upper lobe atelectasis, it can be cleared with endotracheal suctioning to permit surgery. The operation consists of a retropleural approach through the fourth intercostal space. The pleura is separated carefully from the chest wall and the dissection continues until the axygos vein is found, which is suture ligated. The stitch serves also as a traction suture, over a sponge, to retract the pleura. Next, the vagus nerve is identified and that leads to the distal and proximal pouch. The fistula is divided and simply oversewn with nonabsorbable sutures, such as 6.0 Ethiflex.[®] It is important to cover the anastomosis with adjacent pleura to prevent recurrent fistula if the anastomosis leaks.

If there is a long gap between the two ends, several things can be done. One is to perform the anastomosis over a catheter. A circular myotomy is made in the proximal pouch by means of an incision through the muscle right down to the mucosa. The blood supply to the proximal pouch comes in through the mucosa and a myotomy generally provides an extra centimeter of length. The proximal pouch can be widely mobilized without difficulty. In babies with atresia and fistula the proximal and distal ends can usually be approximated. I think it is best to perform a primary anastomosis even if it places tension on the suture line. A retropleural incision is preferable to dividing the two ends even if a leak develops. Had the two ends been divided, a later operation would require dissection through a stiff frozen mediastinum.

Atresia Only

In the baby who has only atresia, the films

will show the radiopaque catheter in the proximal pouch (again, do not use contrast material) and a gasless abdomen. This makes the diagnosis of atresia. Usually the child has a very short esophagus, and it is impossible to draw its two ends together. Other procedures are needed. The suction catheter is placed in the proximal pouch and the baby is taken to the operating room, where a gastrostomy is performed under local anesthesia. While the baby is on the table, contrast material is injected into the stomach. This will outline the distal end of the esophagus, which may or may not extend above the diaphragm, and also detect associated defects. These infants have a high incidence of gastrointestinal atresia, such as duodenal atresia. If such gastrointestinal anomalies are found, they should be repaired immediately.

Gastrointestinal Anomalies

There are presently two options for children with this type of atresia. A temporary cervical esophageal or "spit" fistula can be employed until the baby is 10 or 12 pounds, at which time a bypass can be performed. An alternate procedure—introducing mercury-weighted dilators into the proximal pouch—has been in use for about ten years. At Children's Memorial Hospital we use a 14F dilator. A nurse inserts it through the baby's mouth and places gentle pressure on the esophagus for five minutes out of every hour. It is usually possible to stretch the esophagus enough to eventually perform an end-to-end anastomosis. It sounds like witchcraft, but it does work.

Progress can be evaluated in one of two ways. It is possible to introduce a metal sound through the gastrostomy and up the distal esophagus and a mercury dilator through the mouth into the proximal pouch to obtain a film. A simpler and safer way is to use the mercury dilator, put a little barium into the stomach, and make the baby gag to regurgitate the barium into the distal esophagus. Then you can estimate distance between the two ends. When they get as close as one centimeter, it is fairly easy to make an anastomosis.

If this technique fails or the baby has problems with respiration, it may become necessary to establish a "spit" fistula, and later some form of esophageal bypass. I prefer to use the sub-sternal colon bypass. We have accomplished this in newborns, but it is safer to wait until the baby is older and weighs 10 to 12 pounds.

One Rare Anomaly

The rarest anomaly (and the lesion which is most difficult to diagnose) is called the H-type tracheo-esophageal fistula. The diagnosis is complicated because the babies are able to swallow and do not have initial excess mucus. However, most will have episodes of coughing and choking during feedings. Some will simply present with recurrent pneumonitis and one child was on the cardiac service because it was thought that he was in cardiac failure. Also, they may swallow an excess amount of air, producing marked abdominal distention.

For these reasons, it is advisable to obtain an esophagram for any child with unexplained pulmonary problems. It will not only detect the H-type esophageal fistula, but will reveal vascular rings and hiatus hernia.

Often the diagnosis can be made with a cine-esophagram. The baby should be in the prone position and administered a very thin solution of barium. The baby should be under constant fluoroscopic observation, because as soon as the barium hits the trachea, he'll cough it all out. If you don't have sequential films or see the baby on the cinefluoroscope, the fistula is easily missed. H-type fistulas can be repaired through the neck because they are higher than the standard fistula. We used to go through a right cervical incision but, as you can imagine, the major complication in repair of an H-type esophageal fistula is recurrent nerve injury. If an H-type fistula is suspected but not visible by X-ray, an endotracheal tube may be inserted to simultaneously esophagoscope the child. At that time, a drop or two of such a substance as methylene blue is placed in the endotracheal tube, a little pressure is applied to the airway and the dye will appear in the esophagus if a fistula is present. In our experience, the diagnosis has been made in the majority with cine-esophagram.

Experiential Summary

My most recent review from Children's Memorial Hospital included the years 1970-1973. The classical tracheo-esophageal fistula was the most common. We have encountered an unusual number of H-type fistulas in our series.

There was not a single death from either the atresia or the operation. All the deaths occurred in babies who had other congenital defects, but these were included, regardless of cause. One child had an attempted repair of his cardiac lesion at age six months and died following open

heart surgery. Another, with cleft lip and palate, also lived to be seven or eight months of age and died of aspiration. As a result of this experience, we recommend that if there is a combined cleft lip and palate with esophageal atresia, feeding should be through a gastrostomy until the palate is closed. In all the children who have had an esophageal abnormality and an anastomosis, there is no disordered motility. You can see this on cinefluoroscopy and it increases the already high danger of aspiration. The other babies had multiple defects; imperforate anus was the most common.

Even in the babies who survived, there is a high incidence of associated defects, particularly imperforate anus. Of the survivors, two were operated on in the days when staging was done simply by suture ligation of the fistula and then feeding the baby by gastrostomy. Each of these developed a recurrent fistula. There were two other recurrent fistulas after two layered anastomoses. This may have occurred because tissue was not interposed between the suture line and the trachea. One stricture required surgical correction; one total breakdown of the anastomosis required exteriorization of the two esophageal ends and eventual colon bypass. We presently employ a one-layered anastomosis and I think this has significantly reduced the incidence of stricture. Personally, starting about the tenth postoperative day, I begin passing Tucker dilators more or less to calibrate the anastomosis; I like to continue dilating until I get a 22 Tucker dilator through the anastomosis. Usually, this requires approximately two months.

Dr. Lawrence Michaelis: Lately, there have been several reports of simple fistula ligation and end-to-side anastomosis. Proponents report less problems with stricture and also that they can make a larger anastomosis. What is your opinion?

Dr. John Raffensperger: Doctor Michaelis is referring to a technique that started in Finland and was reported six or seven years ago. Suture-ligation is performed at the junction of the distal esophagus with the trachea. Then the proximal esophagus is simply brought down and an end-to-side anastomosis performed to the distal segment. This anastomosis has been done with 2-0 silk. The operation has not been successful and has been abandoned by most who have tried it. There is a high incidence of recurrent fistula, because the suture of the fistulocut connection has to be tied down just so, to occlude it, but not cut through. ◀

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WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

JANUARY

Family Therapy
LAW IN THE EVERYDAY PRACTICE OF PSYCHOTHERAPY
For: Mental Health Practitioners and Physicians. Two-day workshop, January 13 and 14, 1978; 9:30 to 4:30 PM daily. Speaker: Sandra G. Nye, J.D., MSW., Inst. of Juvenile Research, Chicago, IL. CME Credit: 1 hr. AMA Category 1. Fee: \$70.00. Reg. Limit: 40. Sponsor: Center for Family Studies/The Family Institute of Chicago, 10 E. Huron, Chicago, IL 60611. Contact: Belinda Stone, Secretary for Workshops/Conferences. Co-Sponsor: Institute of Psychiatry, Northwestern Memorial Hospital and Northwestern University Medical School.

ACUTE AND CHRONIC RENAL FAILURE

For: Practicing physicians. Lecture, January 18, 1978. University of Illinois, Chicago, IL. Speaker: Neil Kurtzman, M.D., Prof. of Medicine, Chief, Nephrology Section. Hrs. of Instr.: 2. CME Credit: AMA Category 1. Fee: None. Sponsor: Medical staff of Louis A. Weiss Memorial Hospital (Levinson CME Fund), 4646 N. Marine Drive, Chicago, IL. Contact: Barry J. Millman, Associate Director. Telephone: (312) 878-8700, Ext. 304.

Multiple Sclerosis
INFECTIONS IN IMMUNO COMPROMISED HOSTS
For: Practicing physicians. Lecture, January 4, 1978. 10:00 AM. Louis A. Weiss Memorial Hospital, Chicago, IL. Speaker: Stuart Levin, M.D., Chief, Section Infectious Disease, Prof. of Medicine, Rush Medical School. Hrs. of Instr.: 2. CME Credit: AMA Category 1. Fee: None. Sponsor: Medical staff of Louis A. Weiss Memorial Hospital (Levinson CME Fund), 4646 N. Marine Drive, Chicago, IL. Contact: Barry J. Millman, Associate Director. Telephone: (312) 878-8700, Ext. 304.

Musculo-skeletal Trauma
MUSCULO-SKELETAL TRAUMA
For: All Physicians. Hospital Program on Musculo-skeletal Trauma, January 17, 1978; 8:10-10:00 PM. St. Francis Hospital, 335 Ridge Ave., Evanston, IL. CME Credit: 2 hrs. AAPF Elective and 2 hrs. AMA Category 1. Fee: None. Sponsor: Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. Contact: Mrs. Lillian Husa, Executive Secretary. Telephone: (312) 482-8686.

Psychiatry
THE THEORY OF PSYCHOANALYTIC PSYCHOTHERAPY RE-EXAMINED
For: Psychiatrists and Mental Health Professionals. Lecture series, January 26, 1978, 6:00-7:00 PM, Auditorium, Passavant Pavilion, 303 E. Superior St., Chicago, IL. Speaker: Otto Kernberg, M.D., Professor, Cornell University Medical College. Hrs. of Instr.: 1½. CME Credit: AMA Category 1. Fee: None. Sponsor: Institute of Psychiatry, Northwestern University Medical School, 320 E. Huron St., Chicago, IL. Contact: Leon Diamond, M.D., Director of Graduate Education. Telephone: (312) 649-8058.

Radiology
CAT SCANNING OF THE ABDOMEN
For: All physicians, residents and interns. Lecture, January 11, 1978, 11:00 AM, Auditorium, Martha Washington Hospital, Chicago, IL. Speaker: Leon Love, M.D., Professor, Chairman of Radiology, Foster G. McGaw Hospital, Chicago, IL. Hrs. of Instr.: 1. CME Credit: AAPF Elective and AMA Category 1. Fee: None. Reg. Limit: 110. Sponsor: Martha Washington Hospital, 4055 N. Western Ave., Chicago, IL. Contact: Fernando Villa, M.D., Medical Director. Telephone: (312) 583-9000, Ext. 331.

FEBRUARY

Emergency Medicine
EMERGENCY MEDICINE
For: Emergency Physicians. 5-day workshop course, February 20-24, 1978; 8:00 AM-5:00 PM. Towsley Center, Ann Arbor, MI. CME Credit: 36½ hrs. AAPF Elective and 36½ hrs. AMA Category 1. Fee: \$225.00. Sponsor: Office of Continuing Education, Dept. of Postgrad. Med. & Health Prof. Educ. Contact: Connie Miller, Secretary. Telephone: (313) 763-1423.

Family Medicine
MICHIGAN-INDIANA FAMILY PRACTICE UPDATE
For: Family Physicians. 5-day workshop course, February 5-10, 1978; 8:00 AM-5:00 PM. Boyne Highlands, Harbor Springs, MI. CME Credit: 21½ hrs. AAPF Elective and 21½ hrs. AMA Category 1. Fee: \$175.00. Sponsor: Office of Continuing Education, Dept. of Postgrad. Med. & Health Prof. Educ. Contact: Connie Miller, Secretary. Telephone: (313) 763-1423. Co-Sponsor: Michigan Academy of Family Physicians and Indiana Academy of Family Physicians.

Family Medicine
UPDATE ON BREST CANCER
For: Physicians. Lecture, February 21, 1978; 7:30 PM. Assembly Hall, Sherman Hospital, 934 Center Street, Elgin, IL. Speaker: Steven G. Economus, M.D., Prof. of Surgery, Rush Medical College. CME Credit: 2 hrs. AMA Category 1. Fee: None. Sponsor: CME Committee of Sherman Hospital, 934 Center St., Elgin, IL 60120. Contact: Mary Anne Stiegemeyer, Sec. CME Committee. Telephone: (312) 742-9800, Ext. 649.

Gastroenterology
MANAGEMENT OF DIGESTIVE DISORDERS
For: Practicing physicians. Course, February 21-23, 1978. Center for Continuing Education, 1307 E. 60th St., Chicago, IL. Hrs. of Instr.: 22. CME Credit: AMA Category 1. Fee: \$240.00. Sponsor: University of Chicago, Section of Gastroenterology and Liver Study Unit, 950 E. 59th St., Chicago, IL, Box 400. Contact: Sumner C. Kraft, M.D., Director. Telephone: (312) 947-5567.

General Surgery Trauma
GENERAL SURGERY TRAUMA
For: All Physicians. Hospital Program on General Surgery Trauma, February 28, 1978; 8:10-10:00 PM. Illinois Masonic Medical Center, 836 W. Wellington, Chicago, IL. CME Credit: 2 hrs. AAPF Elective and 2 hrs. AMA Category 1. Fee: None. Sponsor: Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. Contact: Lillian Husa, Executive Secretary. Telephone: (312) 482-8686.

Internal Medicine
ENDOCRINE HYPERTENSION (WITH EMPHASIS ON ALDOSTERONISM)
For: All physicians, residents and interns. Lecture, February 15, 1978, 11:00 AM, Robert C. Hartmann, Sr. Auditorium, Martha Washington Hospital, Chicago, IL. Speaker: Frederick G. Berlinger, M.D., Director, Section of Endocrinology, Masonic Medical Center, Chicago, IL. Hrs. of Instr.: 1. CME Credit: AMA Category 1. Reg. Limit: 110. Sponsor: Martha Washington Hospital, 4055 N. Western Ave., Chicago, IL. Co-Sponsor: Searle Laboratories. Contact: Fernando Villa, M.D., Medical Director. Telephone: (312) 583-9000, Ext. 331.

Medicine
NEPHROLITHIASIS & NEPHROCALCINOSIS
For: Practicing physicians. Lecture, February 1, 1978, 8:00 AM, Chicago, IL. Speaker: Frederic Coe, M.D., Chief, Div. of Nephrology, Michael Reese Medical Center, Chicago, IL. Hrs. of Instr.: 2. CME Credit: AMA Category 1. Fee: None. Sponsor: Medical staff of Louis A. Weiss Memorial Hospital (Levinson CME Fund), 4646 N. Marine Drive, Chicago, IL. Contact: Barry J. Millman, Associate Director. Telephone: (312) 878-8700, Ext. 304.

Medicine
RENAL PHYSIOLOGY AND DIURETICS
For: Practicing physicians. Lecture, February 15, 1978, 8:00 AM, Chicago, IL. Speaker: Neil Kurtzman, M.D. Hrs. of Instr.: 2. CME Credit: AMA Category 1. Fee: None. Sponsor: Medical staff of Louis A. Weiss Memorial Hospital (Levinson CME Fund), 4646 N. Marine Drive, Chicago, IL. Contact: Barry J. Millman, Associate Director. Telephone: (312) 878-8700, Ext. 304.

Musculo-skeletal Trauma
MUSCULO-SKELETAL TRAUMA
For: All Physicians. Hospital Program on Musculo-skeletal Trauma, February 14, 1978; 8:10-10:00 PM. University of Illinois Hospital, 840 S. Wood St., Chicago, IL. CME Credit: 2 hrs. AAPF Elective and 2 hrs. AMA Category 1. Fee: None. Sponsor: Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL. Contact: Mrs. Lillian Husa, Executive Secretary. Telephone: (312) 482-8686.

Pediatrics
AUTOSOMAL CHROMOSOMAL ABNORMALITIES
For: All Physicians. Lecture, February 2, 1978; 9:00 AM. Auditorium, St. Joseph Hospital, 2900 N. Lake Shore Dr., Chicago, IL. Speaker: George F. Smith, M.D. CME Credit: 1 hr. AMA Category 1. Fee: None. Sponsor: St. Joseph Hospital, Department of Pediatrics, Medical Education, 2900 N. Lake Shore Dr., Chicago, IL. Contact: Tina Dabrowski, Secretary. Telephone: (312) 975-3454. Co-Sponsor: Ross Laboratories.

Pediatrics
BIOCHEMICAL GENETICS
For: All Physicians. Lecture, February 14, 1978; 9:00 AM. Auditorium, St. Joseph Hospital, Speaker: George F. Smith, M.D. CME Credit: 1 hr. AMA Category 1. Fee: None. Sponsor: St. Joseph Hospital, Department of Pediatrics, Medical Education, 2900 N. Lake Shore Dr., Chicago, IL. Contact: Tina Dabrowski, Secretary. Telephone: (312) 975-3454. Co-Sponsor: Ross Laboratories.

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EKG

(Continued from page 467)

Answers: 1. E. 2. E.

The onset of atrial fibrillation in this patient with aortic and mitral prosthetic valves resulted in near collapse. Since this was a hemodynamic emergency, D.C. cardioversion was carried out immediately. In patients who are on digitalis in unknown amounts, it is prudent to start with a test D.C. countershock of 20 watt-seconds or so and gradually increase the dose. In our patient 70 watt-seconds resulted in a post-countershock arrhythmia that suggested toxicity. His rapid ventricular response with atrial fibrillation showed that he was not in digitalis toxicity. But his basic heart disease plus therapeutic levels of digoxin responded to a 70 watt-second counter-

shock with a bigeminal rhythm as described.

He spontaneously converted to sinus rhythm at the end of the second ECG strip. The sinus P waves are broad and notched compatible with left atrial enlargement. Digoxin was continued because the initial indication was congestive heart failure. Maintenance of sinus rhythm is related to the underlying heart disease in these patients. There is also a correlation with left atrial size and pressure. Correction of these volume and pressure abnormalities favors sinus rhythm. Quinidine was later required to suppress premature atrial beats which could potentially lead to atrial fibrillation again. Systemic emboli are frequently seen in atrial fibrillation especially with mitral stenosis or ischemic heart disease. Prosthetic cardiac valves are another cause for systemic emboli. For further reading on this aspect of the problem, see "Influence of Etiology of Atrial Fibrillation on Incidence of Systemic Embolism" by R. C. Hinton, *et al.*, in the *American Journal of Cardiology*, 40:509-513, October, 1977.

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HOW TO USE THE NEWER SEROLOGIC TESTS FOR SYPHILIS

PETER E. DANS, M.D. AND FRANKLYN N. JUDSON, M.D./
WASHINGTON, D.C. AND DENVER, COLORADO

Seventy years after Wasserman, serologic tests for syphilis remain the easiest and often the only method for syphilis diagnosis. Continuing modifications in serologic diagnosis have resulted in a confusing array of procedures for those physicians who rarely encounter the disease. The most familiar serologic tests are called non-treponemal because they detect antibody to a lipoprotein antigen resulting from the combination of the organism and host tissues. The VDRL (Venereal Disease Research Laboratory) test and the rapid plasma reagin (RPR) card test are the most widely used examples.¹ These tests have different sensitivities (percentage of true positives detected) at different stages of the disease.² (See Table) They are useful as screening tests because of their simplicity, reproducibility and low cost.

VDRL results are expressed as the highest dilution in which the test is fully reactive, R1, R2, R4, R8, etc. Results of 1:8 or greater are less

likely to be false positive. Lower titer results are seen in latent, late, or adequately treated disease but also are more likely to be false positive.

The likelihood of a test being false-positive varies with the population sampled. False positive reactions are divided into acute (persisting for less than six months) and chronic (persisting for greater than six months). Acute false positive tests are caused by recent vaccinations, infectious hepatitis, infectious mononucleosis, pneumonia, malaria, chicken pox, measles, leprosy, and intravenous drug abuse. Chronic false positives occur in autoimmune disease, especially systemic lupus erythematosus and rheumatoid arthritis, in the aged, in patients with long-term intravenous drug abuse and in some families.

Because of the false-negative and especially the false-positive problem, a second group of tests, using specific treponemal antigens are often required. These tests measure specific antibodies to *Treponema pallidum*. The treponemal tests are the fluorescent treponemal antibody absorption test (FTA-ABS)¹ and the microhemagglutination assay for antibodies to *Treponema pallidum* test MHA-TP.³ The TPI, another treponemal test, proved to be too costly and difficult to perform. It is no longer available except as a research tool. During the past decade, the FTA-ABS has become the confirmatory test of choice in patients suspected of having syphilis. Its greater sensitivity and specificity under ideal conditions led to its widespread adoption. (See Table)



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post and serving as a senior professional associate at the Institute of Medicine for the National Academy of Sciences in Washington, D.C.

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Table 1
OUTLINE OF CLINICAL STAGES OF SYPHILIS

Stage	Characteristic Findings	Usual Onset After Exposure	Persistence of Stage in Untreated Pts.	Darkfield	Serologic Results % Reactive		
					VDRL	FTA	TPI
Primary (1°)	Chancre—may be absent or not visible (e.g., in vagina, mouth)	10-90 days (21 = average)	2-6 weeks	+	78	85	56
Secondary (2°)	Rash—Condyloma latum	6 weeks-6 months	2-6 weeks recurrences in 25% over 2 year period	+(Especially moist lesions)	97	99	94
Latent Early* Late*	None**	After above stages if they develop	May be life long—only 1/3 of untreated pts. develop 3° syphilis	—	74	95	94
Late (3°) Benign	Gumma	2-10 years	Indolent	—	77	95	92
Cardiovascular	Aortic aneurysm Aortic insufficiency	10-30 years	Progressive May be fatal	Aorta may be +	77	95	92
Neurosyphilis Asymtomatic—None Meningovascular— Signs of infection depending on area involved. Paresis—May be minor to frank psychosis. Tabes dorsalis— Signs of posterior column degeneration. Combinations or modifications of above.		5-35 years	Progressive May be fatal	Brain may be +	77	95	92
Congenital Early	Rash, mucous patches rhinitis	Up to 2 years	Neonatal onset esp. severe and often fatal	+	Almost invariably positive in early stage but in neonates, passive placental transfer must be differentiated from active infection. In later stages, results are similar to those in acquired syphilis (above).		
Late	Interstitial keratitis Hutchinson's teeth Eighth nerve deafness May be same as adults i.e., latent or late syphilis	After 2 years	Lifetime	Usually —			

*Variously defined—usual division at 4 years; for epidemiologic purposes (contact tracing) 1 year is more practical.

**For definitive diagnosis—a normal cerebrospinal fluid is necessary (see text).

Technique

A brief description of how the FTA-ABS test is performed is useful in understanding the problems that arise with the test. Lyophilized (dried) *T. pallidum* is reconstituted with distilled water and placed on a slide. The patient's serum, which has been previously diluted with a sorbent prepared from Reiter's treponemes, is then overlaid. If antibodies to *T. pallidum* are present, an antigen-antibody reaction occurs.

A fluorescein-tagged antihuman globulin is added which attaches to the antibody in the antigen-antibody combination. Under the fluorescent microscope, treponemes (which are visible components of this combination) will fluoresce in proportion to the quantity of fluorescein-tagged antihuman globulin reacting with them. Fluorescence intensity is recorded as borderline, 1-4+. However, results are reported as non-reactive, borderline or reactive. The test requires careful attention to slide cleanliness, proper use of the reagents, technician skill in fluorescence reading, care of the microscope, etc.

The MHA-TP test is a simpler treponemal test which measures the ability of serum to agglutinate tanned sheep erythrocytes coated with *T. pallidum* antigen. As with the FTA-ABS test, the serum is pre-treated with a sorbent. The test is a microvolume method and can be quantified but the clinical usefulness of changing titers has not been consistently demonstrated.

The best way to diagnose syphilis when lesions are present—especially in the primary state—is darkfield microscopy. Because of decreasing technical competency in the performance of this test, the FTA-ABS has become a popular initial diagnostic test for patients suspected of early syphilis. We undertook a study because of questions about test performance for this purpose.⁴ We also evaluated the usefulness of the MHA-TP at the reference laboratory.

Methods and Results

Between February, 1973, and April, 1974, we performed VDRL and FTA-ABS tests on all patients at the Colorado General Hospital Venereal Disease Clinic who gave a history of: 1) prior syphilis, 2) a sore or rash in any location, 3) recent contact with persons suspected of having infectious syphilis and 4) reactive syphilis serology. Approximately 22% (1,043) of the 4,750 patients seen during this period fell into these categories. We were able to retest sera from the 226 patients who had borderline or reactive re-

sults in either the FTA-ABS or the VDRL. We sent these sera to the local laboratory and simultaneously to the Center for Disease Control (CDC) reference laboratory.

In both laboratories, 395 serum samples from 226 patients were tested. The results of the VDRL were exactly the same for 337 (85.3%) and within the error of the method, i.e., \pm one dilution for an additional 49 (97.5% VDRL agreement between the two laboratories). The FTA-ABS test did not perform as well. Of 137 sera from 76 patients with syphilis, 80 results were exactly the same. Of 251 sera from 150 patients without syphilis, the results were the same in only 88.

A reactive FTA-ABS test (1 to 4+) obtained at the CDC laboratory correlated well with syphilis diagnosis but similar results from the local laboratory were less comparable. Of those 76 patients with a reactive FTA-ABS at the CDC with assigned diagnoses, 71 (93.4%) had syphilis and 5 had biologic false-positive tests. Of 113 patients with a reactive serum at the local laboratory, 71 (62.8%) had syphilis, and 42 had false-positive tests. Two possible reasons were given for the local laboratory's problems. One of the reagents (the fluorescent antihuman globulin conjugate) was used at a lower than recommended dilution and, secondly, some tests were read by a less experienced technician.

Borderline FTA-ABS results correlated poorly with the diagnosis of syphilis in both laboratories. For example, only 3 of 45 patients with borderline results at the CDC laboratory were determined to have syphilis.

We also studied the performance of the MHA-TP test at the CDC laboratory and found that it was a good confirmatory test for syphilis in that it approximated the results obtained with the FTA-ABS test. In 76 patients with syphilis, all but five had reactive MHA-TP tests. In 150 patients without syphilis, three had reactive tests.

Discussion

We were concerned about the occurrence of nonspecific reactivity in the FTA-ABS test, universally accepted as an excellent confirmatory test for syphilis. This led to both incorrect syphilis diagnoses and unnecessary patient retesting. Review of results in the 1,043 patients tested found only 5 false positives when the test was performed at the CDC—a rate of 0.5%. There were 43 with nonspecific borderline tests—a rate of approximately 4.5%—again, not an unusually high rate in referred or “problem”

sera. Yet, the data are not so reassuring as they appear.

First, one does not routinely have access to testing at the reference laboratory. Therefore, although it is interesting to know how well a test performs under optimal conditions, it is more pertinent to know how it performs under actual field conditions. In this case the performance was inferior to what one might expect from previous studies of the test. Secondly, the performance of the test in the wrong population, i.e., a population with low prevalence, leads to problems even when a test is highly reproducible and performed correctly. The lower the prevalence of a condition in the test population, the greater the likelihood that a positive test will be a false positive. Thus, if one looks at the percentage of patients with syphilis among the 128 patients with borderline and reactive results at the CDC laboratory, only 80 (63%) had syphilis. Borderline reactors constituted the major share of these false positives at CDC (43 of 48). At the local laboratory only 97 (57%) of the 169 patients with borderline or reactive results had syphilis. However, excluding the borderline results, while significant, does not eliminate the problem, since only 54 of the 97 false positives are accounted for by borderline reactors. The principal conclusions that can be drawn from these data are:

1) *Borderline FTA-ABS results don't correlate with the diagnosis of syphilis and are misleading.* Until we have a better understanding of the reasons for this, we recommend that laboratories do not report out borderline results.

2) *The FTA-ABS is a complex test, subject to procedural difficulties.* Failure to perform the test strictly according to specifications can lead to incorrect results. In addition, the end point of the test, (fluorescence reading) is subject to interpretive errors, especially when less experienced technicians are employed. We recommend that laboratories performing the FTA-ABS test institute rigorous quality control of technical performance. This should include surveillance of the equipment (especially the microscope) and the reagents (which should be used according to CDC and manufacturer's specifications). Special attention should be paid to the working dilution of the anti-human globulin conjugate.⁵ The number of technicians performing the test should be limited to a few well-trained individuals. The percentages of borderline and low-level reactivity should be monitored and periodic correlations made with clinical diagnoses.

3) *Even highly specific tests, those with false-positive rates of 0.5 to 1%, perform less well if used in a population with a low prevalence of the disease to be detected.* The FTA-ABS test is increasingly being used as an initial differential diagnostic test in patients with genital sores or suspicion of primary syphilis. In our venereal disease clinic, syphilis prevalence in patients with a sore or rash (where early syphilis was suspected) was only 4%. If we were to test 1000 such patients, only 40 would have syphilis. A test with a 90% sensitivity and a 99% specificity would give positive results in 36 of the 40 patients with syphilis (90% of 40), and 10 false-positives (1% of the 960 patients without syphilis). Therefore, patients without syphilis would be 10 of the 46 positives in a venereal disease clinic population where disease prevalence is much greater than in a general private practice population. In order to increase the test performance, one should validate high likelihood of the disease in the tested patient. One way of doing this is to rely on clinical criteria, darkfield examinations and RPR or VDRL results. In patients with a reactive VDRL, the syphilis rate was 68%. If we do comparable calculations for 1000 such patients using a test with 90% sensitivity and 99% specificity, we would detect 90% of the 680 patients with the disease (612 would be true positives and 1% of the 320 negatives, or 3, would be false positive). Only 3 of 615 patients with positive results would be false-positives.

The foregoing makes it clear that even an excellent test such as the FTA-ABS needs to be used in the right population to perform well. Therefore, we recommend that the FTA-ABS test be limited to patients with a reactive RPR or VDRL, or those believed to have late syphilis.⁶ If one suspects primary syphilis, darkfield microscopy and an RPR or VDRL are essential. If both are negative, highly suspect patients should have one or two repeat darkfields. If these are negative, the RPR or VDRL should be rechecked in two to four weeks (this recheck is employed in all patients). Patients with a known reactive FTA-ABS test should not have a repeat test, since reactivity rarely disappears even after adequate treatment.⁷ Our recent article suggested measures that laboratory directors could use to decrease their workload and improve their performance of the FTA-ABS.⁴

4) *The MHA-TP is a good confirmatory test for syphilis.* It is a much simpler test and does not require fluorescent microscopy. It could

be used in lieu of the FTA-ABS test in regional laboratories. It is, however, subject to false positive and false negative results and the FTA-ABS can be a useful arbiter in problem cases. In fact, the current practice at the Illinois state laboratory is to use the RPR as the screening non-treponemal test, the MHA-TP as the first-line confirmatory treponemal test and the FTA-ABS when there is any conflict in the results between them.

In short, the use of any test, even a very good one, may lead to confusion. In an age where technology is increasingly important for diagnosis, the risk of misleading results increases. Practitioners would profit from a general re-examination of their use of laboratory tests. In this regard, a recent review of the subject is well worth reading.⁸

Acknowledgment

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A Self-Assessment Quiz

Diagnostic Tests in Syphilis

BY LOIS MATSUOKA, M.D., AND BRUCE BENNING, M.D./CHICAGO

Select the one best answer:

1. All of the following are involved in the VDRL test except:
 - A. IgG immunoglobulin
 - B. IgM immunoglobulin
 - C. Complement
 - D. Heat-inactivated serum of patient
 - E. Cardiolipin-cholesterol-lecithin antigen
2. The most specific test for detecting syphilis is:
 - A. Venereal disease research laboratory test (VDRL)
 - B. Fluorescent treponemal antibody absorption test (FTA-ABS)
 - C. Wasserman test
 - D. Rapid plasma reagin (RPR)
 - E. Kolmer test
3. Materials necessary to perform the FTA-ABS test include:
 - A. Lyophilized (dried) *Treponema pallidum*
 - B. Patient's serum
 - C. Fluorescent-tagged antihuman globulin
 - D. All of the above
 - E. None of the above
4. False positive VDRL results may be caused by:
 - A. Recent vaccinations
 - B. Pneumonia
 - C. Infectious hepatitis
 - D. Chicken pox
 - E. All of the above
5. The first test that usually becomes positive in syphilis is:
 - A. VDRL



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- B. FTA-ABS
 - C. Wasserman
 - D. RPR
 - E. Kolmer
6. A positive serology is most likely to be present in:
 - A. Incubating syphilis
 - B. Primary syphilis
 - C. Secondary syphilis
 - D. Late syphilis
 - E. Tertiary syphilis
 7. The FTA-ABS test will be positive in:
 - A. Yaws
 - B. Pinta
 - C. Bejel
 - D. All of the above
 - E. None of the above
 8. Which of the following is not characteristic of *Treponema pallidum* under the microscope?
 - A. Rotation about the long axis like a corkscrew
 - B. Slow forward and backward movement
 - C. 5 to 20 μ m in length
 - D. Well-defined nucleus
 - E. Slender, spiral organism with 8 to 24 coils
 9. A positive darkfield examination will be diagnostic of syphilis in all of the following lesions except:
 - A. Penile chancre, primary syphilis
 - B. Mouth chancre, primary syphilis
 - C. Condyloma lata, secondary syphilis
 - D. Palmar macules, secondary syphilis
 - E. Annular lesions, secondary syphilis
 10. Retreatment should be considered when:
 - A. Clinical signs or symptoms persist or recur
 - B. There is a sustained fourfold increase in the titer of nontreponemal tests
 - C. An initially high-titer nontreponemal test fails to show a fourfold decrease within a year
 - D. All of the above
 - E. None of the above

Answers

1. C: The VDRL is based on the concept that in syphilis, IgG and IgM are produced against a nonspecific lipoidal antigen that results from the interaction of the spirochete with the host tissue. These serum immunoglobulins can be quantitatively measured in the laboratory against a standard cardiolipin-cholesterol-lecithin

antigen. The VDRL titer reflects the activity of the disease. The rapid plasma reagin (RPR) test is another nontreponemal test which has been automated to screen large numbers of patients.

2. B: The VDRL, Wasserman, RPR and Kolmer tests measure nonspecific reaginic antibodies. False positive reactions can occur. The FTA-ABS test involves an antitreponemal antibody and thus is the most sensitive and specific test for syphilis.

3. D: To perform the FTA-ABS test, dried *Treponema pallidum* is placed on a slide. The patient's serum is then overlaid. An antigen-antibody reaction will occur if antibodies to *T. pallidum* are present. A fluorescent-tagged anti-human globulin is then added which attaches to the antibody in the antigen-antibody combination. The treponemes will fluoresce under the fluorescent microscope and results are reported as non-reactive, borderline or reactive. (paraphrased from preceding article by Dans, Peter and Judson, Franklin: How to Use the Newer Serologic Tests for Syphilis.)

4. E: False positive VDRL results may occur in acute viral or bacterial infections or vaccinations. False positive VDRL reactions lasting more than six months occur in autoimmune disease, drug addiction and aging. In such cases, an FTA-ABS will help to exclude syphilis.

5. B

6. C: Serological results are almost 100% positive in secondary syphilis. (See chart in preceding article by Dans, P. and Judson, F.) The VDRL may be negative in up to 30% of primary or late syphilis cases. For that reason, darkfield examination and repeat serology in one to two weeks is necessary in suspected cases of early syphilis when the initial VDRL is negative. If a VDRL test is negative in suspected late syphilis, the more sensitive FTA-ABS should be obtained.

7. D: The FTA-ABS test is positive in non-venereal treponematoses.

8. D

9. B: The darkfield examination is a useful diagnostic test in penile chancres and condyloma lata. A darkfield examination of the mouth may be misleading since regular spirochete inhabitants of the mouth have a similar histological appearance to *T. pallidum*. Palmar macules and papulosquamous syphilids are occasionally positive.

10. D: See: Venereal Disease Control Advisory Committee, Center for Disease Control: Syphilis: Recommended Treatment Schedules, 1976. *Annals of Internal Medicine* 85:94-96, 1976.

Doctor's News

CME RULES AT LAST—It is anticipated that rules and regulations for Continuing Medical Education requirements for license renewal will be promulgated by the Department of Registration and Education on or about January 1, 1978. The full text and brief explanation will be carried in the January *IMJ*, if available.

Current proposals would mandate 100 hours every two years, 50 of which must be in Category I. For the first pre-renewal period, January 1 to March 31, 1978, the Department may require evidence of 12 hours of CME, one-third of which must be in Category I. This may include credits earned at any time during the period July 1, 1976 to March 31, 1978.

Specific reporting requirements, possible waivers and verification will be detailed with the regulations. Watch the next issue for the complete report.

MID-WINTER VIRGIN ISLANDS CLINICAL CONFERENCE—The Virgin Islands Medical Society, in conjunction with the faculty at Johns Hopkins University School of Medicine, has announced that the third annual Mid-winter Virgin Islands Clinical Conference is scheduled for January 26-28, 1978. The program is designed to be of benefit to physicians in general practice, internal medicine, general surgery, OB-Gyn and pediatrics. Lectures and seminars are scheduled, and participants will be eligible for 14 credit hours of Category I CME credit. The conference will be held in Bluebeard's Castle Hotel, St. Thomas, U.S. Virgin Islands. Further information may be obtained by writing Peter A. Curreri, M.D., Chairman, Third Annual Clinical Conference, Red Hook Shopping Center, Box 39, St. Thomas, V.I. 00801. Registration is limited.

A BOON TO STUDENTS—The Sangamon County Medical Society Charitable Trust recently awarded approximately \$20,000 to the SIU School of Medicine Student Loan Fund.



Mr. Lee G. Gamage (L), Senior Vice President and Trust Officer at the Springfield Marine Bank in Springfield awarded the check to Dean Doolen, asst. dean for student affairs at SIU. Robert L. Prentice, M. D., (R) Sangamon County Medical Society president, serves with Gamage as administrator of the Trust.

Upon receiving the check, Dean Doolen noted that increasing costs mandate such a fund "for the greater percentage of our students to complete their medical education," adding that federal funding has been increasingly restricted in recent years. Doolen stated that interested students should contact

his office, 801 N Rutledge, Medical Instructional Facility, Springfield.

PHYSICIANS IN THE NEWS—Donald F. Pochyly, M.D., M.Ed., River Forest, has been named provost and acting president for the University of Health Sciences/Chicago Medical School. In assuming the post, he leaves his position as director of educational development for the UC Medical School, School of Related Health Sciences and School of Graduate and Postdoctoral Studies . . . Frank Ellis, M.D., Chicago, has been named president of the American Public Health Association . . . William R. Barclay, M.D., Chicago, has been elected president pro tem of the newly-formed Chicago Thoracic Society. Doctor Barclay, editor of the *Journal of the American Medical Association*, is a Chicago Lung Association past president and serves the AMA as director of scientific activities. The Chicago Thoracic Society also named Park Ridge physician G. Stephen Scholly, medical director of inhalation therapy at Lutheran General Hospital, to the position of secretary-treasurer.

Herbert Meltzer, M.D., Chicago, is among eight recipients of a special HEW award to establish national Mental Health Clinical Research Centers. In announcing the awards, the National Institute of Mental Health spokesman stated that the centers will focus on major problems in genetic, biochemical, psychopharmacologic and psycho-social treatment of mental pathologies, and reflect a commitment to "a balanced approach to studying the nature, causes and treatment of mental illness." Doctor Meltzer's work centers on biological and behavioral aspects in major psychoses. His colleagues at the Illinois State Psychiatric Institute and Manteno State Hospital will utilize the funds to continue their multidisciplinary, longitudinal studies . . . John L. Wright, M.D., Bloomington, has been elected chairman of the physician-advisory board of the American Association of Medical Assistants. Doctor Wright has been a member of the AAMA Physician-Advisory Board for two years, and serves that organization as a survey team member for AMA/AAMA accreditation. . . . The American Academy of Family Physicians elected Greenville physician Boyd E. McCracken to their 1977-78 Board of Trustees at their recent meeting in Las Vegas . . . Gerald W. Grawey, Peoria, has been named a vice president representing occupational medicine for the American College of Preventive Medicine . . . Leslie Schwartz, M.D., Chicago, has been elected president of the physician-staff at Belmont Community Hospital. Harold J. Lasky, M.D., has assumed a seat on the ISMS Board of Trustees, replacing Alfred J. Faber, M.D., Northbrook, who resigned. A Chicago radiologist, Doctor Lasky will represent the Third Trustee District until the 1978 Annual Meeting.

NEW AMA COUNCIL/COMMITTEE MEMBERS—The American Medical Association recently announced new appointees to their councils and committees. Three Illinois physicians were among those chosen for posts. Allwyn H. Gatlin, Chicago, will serve on the Advisory Committee on Graduate Medical Education. William Lees, M.D., Chicago, president of the Illinois Council for Continuing Medical Education, has been named to the AMA Advisory Committee on Continuing Medical Education, and Steven Cooper, North Chicago, will assume a post on the Committee on Allied Health Education and Accreditation.



Self-Care & Health Care Costs

Controlling health care costs is the major challenge confronting our profession. The issue currently ranks as a favorite topic of the media, politicians, bureaucrats and general public. Although the causes of increased medical spending are well documented, a long-term solution is not readily apparent.

Hastily-formulated, stop-gap measures will accomplish nothing. Nor will pointing the finger of blame at the health care system. Granted, physicians and other elements of the system play a role in rising costs. However, the patient is responsible for a considerable amount of the increase.

Each patient must bear the responsibility for his health. As physicians, we have a corresponding responsibility to educate our patients about the dangers of obesity, drug and alcohol abuse, poor nutritional habits, use of tobacco and lack of exercise. When patients ignore their responsibility, there is an increase in health care costs!

Those who blame the system for high costs must be convinced to look toward society itself for some answers. Poor housing, pollution, poverty, lack of education, stress, etc., all contribute to the health status of the population.

It's time to expand the focus of cost containment efforts. In addition to treating the sick, we must encourage positive programs to maintain health. We cannot allow the health care system to continue being the scapegoat for patient irresponsibility and the shortcomings of society.

A handwritten signature in cursive script that reads "George T. Wilkins, Jr.".

George T. Wilkins, Jr., M.D.

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PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA

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